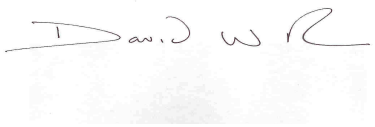
Public Document Pack

Health and Wellbeing Board

Wednesday, 14 January 2015 2.00 p.m.
Karalius Suite, Stobart Stadium, Widnes



Chief Executive

Appendices and attachments for items 3A and 5B can be accessed via the following link:
www.halton.gov.uk/hwbappendix. If there you are unable to open the link please contact Gill Ferguson as detailed below.

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 11 March 2015

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

The dates of Health and Wellbeing Board meetings in 2015/16 are as follows:

2015
11 March
13 May
8 July
16 September
4 Nov

2016
13 Jan
9 March

All meetings will be held on a Wednesday at 2.00 pm in Karalius Suite, Halton Stadium, Widnes.

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 12 November 2014 at Karalius Suite, Halton Stadium, Widnes

Present: Councillors Philbin, Polhill, Woolfall and Wright and E. Anwar, K. Appleton, S. Banks, S. Boycott, G. Ferguson, A. Marr, A. McIntyre, E. O'Meara, D. Parr, N. Rowe, M. Trehare, J. Wilson, S. Yeoman.

Apologies for Absence: K. Fallon, D. Lyon and N. Sharpe.

Absence declared on Council business: None

Also in attendance: Dr Mandel and two representatives of North West Ambulance.

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB22 MINUTES OF LAST MEETING

The Minutes of the meeting held on 17 September 2014 having been circulated were signed as a correct record.

HWB23 INTEGRATED SEXUAL HEALTH SERVICE

The Board was advised that as part of their new Public Health responsibility, local authorities were mandated to commission the following sexual health services:

- Contraception outside the GP contract;
- HIV Testing;
- Chlamydia testing as part of the National Chlamydia Screening Programme and treatment;
- Testing and treatment of other sexually transmitted infections;
- Sexual health aspects of psycho sexual counselling; and
- Any sexual health specialist services e.g. sexual health promotion, young persons' services, HIV prevention, outreach work, teenage pregnancy.

It was noted that prior to 1st November 2014 these services were delivered under four separate contracts, each with a different area of focus or responsibility but with strong interdependencies between the services.

Halton had participated in a review of sexual health services provided across Cheshire and Merseyside in late 2013. This resulted in the development of a common specification for integrated sexual health services combining the elements listed above which local authorities were able to adapt to meet local circumstances.

Members were advised that the Halton specification was adapted to fit local need and took account of feedback from two public and stakeholder surveys and several focus groups held with young people and young mums in the Borough. The tender opportunity to deliver the integrated sexual health services was advertised on the Due North Chest e-procurement system at the end of March 2014 and interviews of shortlisted candidates were held on the 13th June 2014. It was noted that the bid by Warrington and Halton NHS Hospitals Trust (WHNHST) was the most economically advantageous and was, therefore, successful. The report outlined key features of the successful bid and advised that the new contract commenced on the 1st November 2014.

Dr Mandel, consultant and Lead Clinician from WHNHST, attended the meeting and delivered a presentation which outlined the benefits of the provision of the new integrated service.

RESOLVED: That the contents of the report be noted along with the accompanying presentation.

HWB24 CHILD SEXUAL EXPLOITATION

The Board considered a report which provided a summary of the approach in Halton to addressing Child Sexual Exploitation (CSE) within the Borough.

Halton, along with Cheshire East, Cheshire West and Warrington had begun to focus on CSE prior to the Rotherham report following concerns in other areas such as Rochdale and Oxfordshire. Learning from these cases, a range of actions had been undertaken details of which were outlined in the report. It was highlighted that a website www.knowandsee.co.uk had been launched by Warrington, Halton, Cheshire East and West Councils which provide help and support to young people.

The Board was advised that following the publication of the Rotherham Report, a further review of Halton's approach to CSE had been undertaken. The Review would be led and co-ordinated by Halton LSCB and an interim report would be produced at the end of October 2014 which would identify the immediate issues to be addressed to ensure that children and young people were safe. The final report would then be completed by December 2014 and presented to a private session of full Council. The LSCB would then publicise the findings and response and if any urgent action was identified the appropriate action would be taken immediately.

In parallel to this work, Halton was establishing a co-located multi-agency CSE Team which would include colleagues from Cheshire Police and the NHS locally. In addition, the Cheshire LSCBs were working collaboratively with Cheshire Police and the PCC to share best practice and review the "high risk" factors identified in the Rotherham Report, on a wider Cheshire footprint.

Arising from the discussion it was agreed that the possibility of inviting Voluntary Sector organisations to the PAN Cheshire Communication Group be explored.

Also in attendance were representatives from the North West Ambulance Service. They advised the Board that this had been a challenging year for the Service with a 8-9% increase in activity in Halton. In response to recent incidents in the Borough the funding of an extra vehicle had been obtained from the CCG and an acute visiting team had been introduced.

RESOLVED: That the Board note the response by Halton Council and its partners in the Local Safeguarding Children Board to Professor Jay's report into Child Sexual Exploitation in Rotherham.

Strategic Director Children and Enterprise

HWB25 PUBLIC HEALTH ANNUAL REPORT 2013-14: DRINKING LESS AND LIVING LONGER

The Board considered a report from the Director of Public Health, which provided Members with information on the 2013-14 Annual Report: Drinking Less and Living Longer. The draft Annual Report was attached as Appendix 1 to the report.

The Board was advised that this year's Public Health Annual Report focussed on the topic of alcohol related harm

and set out how work was taking place in partnership to reduce the alcohol harm for individuals, families and communities. It was reported that alcohol-related harm affected all age groups within Halton. The report was therefore written from a life course perspective and set out key actions that would be taken for each group. A communities chapter was also included which covered issues that affected people of all ages, e.g. crime and community safety, alcohol availability and price.

The Board was further advised that reducing alcohol-related harm was chosen as a topic as it demonstrated the importance of working in partnership and what could be achieved when organisations worked together across organisational boundaries. It was also timely as the Public Health Team were currently working in partnership to develop a local alcohol harm reduction strategy. In addition, Halton was only one of twenty areas in the country to be awarded the status of being a Local Alcohol Action Area.

It was reported that chapters included in the report were as follows:-

- Promoting an alcohol free pregnancy and protecting Halton babies and toddlers from alcohol related harm;
- Reducing under-age drinking in Halton;
- Promoting safe and sensible drinking among adults;
- Promoting safe and sensible drinking among older people; and
- Keeping our local community safe from alcohol related harm.

Each chapter outlined the current levels of alcohol-related harm, described current local activity to reduce alcohol related harm, outlined gaps in current activities and made recommendations for future actions.

RESOLVED: That the Board note the contents of the report and support the recommendations.

HWB26 HALTON ALCOHOL STRATEGY: REDUCING ALCOHOL-RELATED HARM ACROSS THE LIFE COURSE, 2014-2019

The Board considered a report of the Director of Public Health, which presented the final draft of the Halton Alcohol Strategy: Reducing Alcohol-related harm across the life course. The report set out the vision, outcomes and objectives of the Alcohol Strategy.

The Board was advised that the Halton Alcohol Strategy outlined actions aimed at rebalancing the relationship Halton had with alcohol. The strategy took a life course approach to reducing alcohol-related harm at all stages of life from birth to old age and also included a "Communities" chapter.

Members were advised that the strategy built upon the effective work that had been undertaken by partners locally and had been written in collaboration with all partners who had agreed the vision, outcomes, objectives and actions. The strategy was also supported by a detailed action plan outlining actions, the responsible leads, timescales and outcomes to be achieved. The plan would be monitored by the Alcohol Strategy Implementation Group and outcomes reported to the Safer Halton Partnership, Health and Wellbeing Board and all other relevant bodies.

It was also reported that a formal public consultation would be undertaken to enable local people to provide feedback and insight to the final version of the strategy and action plan. In addition, it was reported that the strategy would also be presented to the following Boards for input and discussion:-

- Safer PPB;
- Safer Halton Partnership Board;
- Children's Trust Board;
- Halton Clinical Commissioning Group Executive Board; and
- Executive Board.

In addition, it was noted that Halton was one of only 20 areas in the country to be awarded the status of being a Local Alcohol Action Area. The award provided support from the Home Office and Public Health England and related to addressing the harm from alcohol across three areas – health, crime and anti-social behaviour, and diversifying the night time economy. Key partners had been involved from local authority, health and community safety and an action plan had been developed. This work was integrally linked to the development of the alcohol strategy and action plan.

Members were also advised that this report and the Public Health Annual Report would be submitted to a future meeting of the Council's Regulatory Committee.

RESOLVED: That the Board

1. note the contents of the report; and

2. support the strategy outcomes, objectives and actions.

HWB27 EARLY INTERVENTION

The Board received a report of the Strategic Director, Children and Enterprise, which provided a summary of the revised Early Help Model and sought approval of the governance arrangements. Early Help and Support was an approach established in Halton in 2010 with an overarching Early Help Strategy launched in April 2013. There had since been an agreement to develop the next stage of Early Help.

Following work by a sub group of the Early Help and Support Group, in September 2014, Halton launched its locality model based on the realignment of the current Integrated Working Support Teams, and the Intensive Family Work. This new approach was known as Early Intervention. The new Early Intervention Model had set up three locality Early Intervention Teams, one in Widnes and two in Runcorn, reflecting the current volumes of referrals. Each team consisted of staff from the Integrated Working Support Teams, family support teams and intensive family work teams. In November the staff member from the police previously seconded to the Troubled Families would move to be part of the CART.

Members were advised that the next phase of the development of the programme was to work with key partners in the police, health and adult services to establish the correct links with the locality services. In addition, it was suggested that the Health and Wellbeing Board would act as the governing body for Halton's approach to Early Intervention, setting the strategic direction and acting as the driver for planning, co-operation and working. It would also ensure effective information sharing and performance management systems were established across partners. The Board would receive regular reports from the Partnership Board. It was proposed that:-

- the current Troubled Families Strategic Group would be revised and renamed as the Partnership Strategic Board;
- the Partnership Board would be accountable to the Health and Wellbeing Board; and
- the current Early Help and Support Group of the Children's Trust Executive would be responsible for operational delivery and ensuring services were delivered in line with the agreed business plan,

priorities and local needs.

RESOLVED: That

1. the governance arrangements for Early Intervention be agreed;

2. all partners commit to working with the locality based Early Intervention Teams; and

3. all partners commit to ensuring the appropriate information sharing arrangements are in place and that CART can access the relevant data bases.

HWB28 HALTON CANCER STRATEGY

The Board considered a report of the Director of Public Health, which provided a final version of the joint Halton Cancer Strategy 2014-2019, along with the supporting action plan. The prevention and early detection of cancer was identified as one of the five health and wellbeing priorities for Halton via the Joint Strategic Needs Assessment. The Halton Cancer Strategy, in line with the Joint Health and Wellbeing Strategy, took a life course approach from prevention and early detection through to treatment and survivorship. The vision was to deliver on reducing the under-75 mortality rates from cancer, by preventative methods, increased early detection rates and tangible improvements in cancer services.

The strategy had been developed and endorsed by the Halton Action on Cancer Board which included representation from the Strategic Clinical Network, secondary care cancer teams, the GP Clinical Lead for Cancer, the Director of Public Health, the CCG Commissioning Lead, Voluntary Sector representation and had been further supported by numerous public and patient engagements as detailed within the strategy.

It was noted that cancer outcomes were monitored in both the CCG Outcome Indicator Set and the Public Health Outcomes Framework. The indicators included:

- Improved uptake of cancer screening;
- Increased numbers of cancer diagnosed at an early stage;
- Reduced mortality from under 75 cancer;
- Improved one and five year survival rates from cancer, in particular, breast, lung and colorectal.

RESOLVED: That

1. the Board approve and support the contents of the strategy; and

2. the Board support the implementation of the attached action plan for all partners.

HWB29 DUE NORTH: THE REPORT OF THE INQUIRY ON HEALTH EQUITY FOR THE NORTH

The Board considered a report which provided an overview of Due North: the report of the Inquiry on Health Equity for the North, which was the outcome of an independent inquiry commissioned by Public Health England to examine health inequalities affecting the North of England.

The inquiry brought together expertise from people working across the North of England from universities, local government, the NHS and the voluntary and community sector. Due North highlighted that the North of England had persistently had poorer health than the rest of England and that this gap had continued to widen over four decades. Also, there was a gradient in health across different social groups within the North: on average poor health increased with increasing socio-economic disadvantage, resulting in the large inequalities in health between social groups that were observed today.

In addition, the report highlighted that austerity measures introduced by Central Government since the 2008 recession had been making the situation worse, with the burden of local authority cuts and welfare reforms falling more heavily on disadvantaged Northern local authorities such as Halton. In addition, the report recognised that Northern regions currently had limited collective influence over how resources and assets were used in the North of England and that hindered action on health inequalities. Greater devolution of powers and resources to cities and local government was required to drive economic growth and reduce regional inequalities in England.

Due North set out the following 4 high level recommendations to tackle the root causes of health inequalities both between the North and between the North and the rest of England:-

1) tackle poverty and economic inequality within the North and between the North and the rest of England;

2) promote healthy development in early childhood;

3) share power over resources and increase the influence that the public had on how resources were used to improve the determinants of health;

4) strengthen the role of the health sector in promoting health equity.

The report also outlined local activity within Halton to improve health equity in line with suggested actions and recommendations. Key activities to reduce health inequalities in Halton related to the Due North recommendations were detailed in the report. A copy of a discussion document on Due North would be circulated to Members for comment following this meeting.

RESOLVED: That

Halton take forward the Due North report recommendations, especially those related to:- | Director of Public Health

a) Lobbying Central Government for greater devolution of powers and resources to cities and local government;

b) Tackling poverty and economic inequality;

c) Developing a social value approach to procurement;

d) Promoting healthy development in early childhood;

e) Developing the capacity of local communities to engage with and influence local decision-making; and

f) Addressing premature mortality through primary care, with a focus on improving treatment and outcomes among older people living with long-term conditions.

HWB30 DISABLED CHILDREN'S CHARTER

The Board considered a report of the Strategic Director, Children and Enterprise, which sought approval from Every Disabled Child Matters and the Children's Trust, Tadworth for the Board to support the Disabled Children's Charter. The report outlined details of the seven commitments which, by signing the Charter, the Board would be agreeing to meet within 12 months. It was also noted that work was already being undertaken in the

Borough to meet the requirements of the Children and Families Act April 2014, it was therefore suggested that these two areas of work continue to be combined.

RESOLVED: That

1. the Board accepts the Charter; and
2. the Charter is reviewed annually.

Strategic Director Children and Enterprise

HWB31 HEALTH & WELLBEING GRANTS

The Board considered a report which provided an update on the progress of the Health and Wellbeing Grants which were launched at the Vintage Rally in September 2014. Four categories of application were available: Recognition Award, Community Group Award, Healthy Workplace Award and Health School Award. Three rounds of applications would be invited with deadlines of 17th October 2014, 19th December 2014 and 27th March 2015.

It was noted that the first round of grants received 17 applications for funding and the Panel had agreed eleven grants, one was deferred for further information, one was rejected as it would have been retrospective funding and four were referred to other avenues for support. The total amount awarded in the October round was £5,085. Three of the applications were for recognition awards for contributions to supporting Health and Wellbeing. Full details of all applications received and the grants awarded were outlined in the report.

RESOLVED: That the report be noted.

Meeting ended at 3.55 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 14th January 2015

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Family Nurse Partnership

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide background information for the presentation on the Family Nurse Partnership.

2.0 RECOMMENDATION: That the Board note the contents of the report and presentation

3.0 SUPPORTING INFORMATION

What is Family Nurse Partnership (FNP)?

3.1 FNP is an evidence- based maternal and early years public health programme that provides intensive support to young, first time mothers and their families. Using a psycho-educational approach the programme offers regular home visits delivered by highly trained nurses, from early pregnancy up until the child's second birthday.

3.2 The Family Nurse Partnership is a preventative programme aimed at improving the life chances of the most disadvantaged children and families in society. The main aims of the programme are as follows:

- To improve pregnancy outcomes, so that the baby has the best start in life
- To improve the child's health and development by developing parenting knowledge and skills
- To improve parents' economic self-sufficiency, by helping them to achieve their aspirations (such as employment or returning to education)

3.3 FNP also enables young mothers and fathers to:

- Build positive relationships with their baby and understand their baby's needs
- Make the lifestyle choices that will give their child the best start in life

- Build their self-efficacy (belief and ability to plan and achieve their goals)
- Build positive relationships with others, modelled by building a positive relationship with the family nurse

3.4 Evidence from research on the effectiveness of FNP shows that FNP improves the lives of vulnerable young children and mothers in the short, medium and long term:

- Improved pregnancy outcomes
- Reduced child abuse and neglect
- Improved school readiness
- Reduced youth crime
- Improved employment for mothers, and fewer subsequent pregnancies with bigger gaps between births

National Context

3.4 There is a Government commitment to increase the number of Family Nurse Partnership places available in England at any one time to 16,000 by 2015.

3.5 Local Authorities will take on the responsibility for commissioning FNP in 2015. Strategic commitment will be a key priority to ensure the long-term sustainability of the programme.

FNP in Halton

3.6 The Family Nurse Partnership has been commissioned by NHS England to provide a service in Halton. Staff have now been recruited and started seeing patients in November 2014. The provider organisation is Bridgewater Community Health Care Trust, who are licensed to deliver the programme.

3.7 A Halton Family Nurse Partnership Board has also been established, including representatives from NHS England, CCG, Bridgewater, Public Health and partner organisations.

3.8 Commissioning responsibility for FNP will transfer to Halton Borough Council in October 2015.

4.0 POLICY IMPLICATIONS

4.1 Halton's Health and Wellbeing Strategy identifies Improved Child Development as one of five key priorities for action. This priority was chosen for a number of reasons including; child development has a significant impact on child health and wellbeing which remains into adult life; Halton has a high percentage of children who do not reach a good level of development by age five and; it is amenable to change through evidence- based interventions.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Funding for FNP (along with the commissioning responsibility) will transfer to Halton Borough Council in October 2015. Assuming that the service operates within agreed budgets, no adverse financial implications are expected.

Independent studies shows that the Family Nurse Partnership programme results in financial benefits to participants, the public purse and wider society.

- Economic benefits increase over time as the children get older but there are indications that **the cost of the programme is recovered by the time the children are aged four** for the highest risk families and certainly by age 12
- A recent updated study by Washington State Institute for Public Policy estimated long-term benefits of almost $23,000 per participant.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Early Help and Support is one of the key priorities for the Halton Children and Young People's Plan. As well as supporting this priority the FNP initiative also promotes the overarching priority of "Working Together".

6.2 Employment, Learning and Skills in Halton

One of the key aims of the Family Nurse Partnership is to improve the economic self-sufficiency of parents by helping them to achieve their aspirations. This could include accessing employment opportunities or returning to education following the birth of their child.

6.3 A Healthy Halton

As outlined in 4.1 above, the Family Nurse Partnership contributes directly to addressing Health and Wellbeing priorities.

6.4 A Safer Halton

The Family Nurse Partnership aims to improve life chances and build positive relationships within families which in turn should lead to reductions in youth crime, domestic violence and child abuse/ neglect.

6.5 Halton's Urban Renewal

N/A

7.0 RISK ANALYSIS

A strategic commitment is required from partner agencies if FNP is to succeed locally.

8.0 EQUALITY AND DIVERSITY ISSUES

This is in line with all equality and diversity issues in Halton.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

There are none within the meaning of the Act.

REPORT TO: Health and Wellbeing Board

DATE: 14th January 2015

REPORTING OFFICER: Simon Banks, Chief Officer

PORTFOLIO: Health and Wellbeing

SUBJECT: Developing a Halton response to the NHS *Five Year Forward View*

WARD(S): Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 On 23rd October 2014 NHS England, in partnership with five other national organisations involved in setting the strategic direction and regulatory framework for the NHS, published *Five Year Forward View*. On 4th December 2014 NHS Halton Clinical Commissioning Group (CCG) commenced a two month dialogue with local people and partners in regard to a Halton response to *Five Year Forward View*. Strategic decisions will need to be made by NHS Halton CCG Governing Body following *Five Year Forward View,* particularly in regard to new models of care.

2.0 **RECOMMENDATION: The Board are invited to review and contribute to the document produced by NHS Halton CCG.**

3.0 **SUPPORTING INFORMATION**

3.1 The *Five Year Forward View* was published on 23rd October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

3.2 The purpose of the *Five Year Forward View* is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the

potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

3.3 The *Five Year Forward View* starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

4.0 POLICY IMPLICATIONS

4.1 The *Five Year Forward View* highlights (www.england.nhs.uk/ourwork/futurenhs/) that the NHS has dramatically improved over the past fifteen years. Outcomes are better, waits are shorter and patient satisfaction is high. Nonetheless, quality of care can be variable, preventable illness is widespread and health inequalities are deep-rooted. The needs of patients are changing, new treatment options emerging and service pressures are building. There is a broad consensus on what a better future should look like, which needs new partnerships and approaches.

4.2 The *Five Year Forward View* states that the warnings of the Wanless Report were ignored, and a radical upgrade of prevention and public health is now needed. More control of their own care needs to be passed to people who need health services. Barriers between family doctors and hospitals, physical and mental health and health and social care need to be broken down.

4.3 A small number of radical new care delivery options will be supported, these options include:

- Multispecialty Community Provider
- Primary and Acute Care Systems
- Urgent and Emergency Care Networks
- Viable Smaller Hospitals
- Specialised Care
- Modern Maternity Services
- Enhanced Health in Care Homes

Whilst new care models will be developed and supported, *Five Year Forward View* states that the foundation of NHS care will remain list-based primary care. As part of this commitment there will be a 'new deal' for GPs.

4.4 To support these changes, the national leadership of the six

signatory bodies to *Five Year Forward View* have committed to act more coherently together. They have also committed to providing meaningful local flexibility over payment rules, regulatory requirements and other mechanisms to support change and innovation.

4.5 To sustain a comprehensive, high-quality NHS, *Five Year Forward View* states that action will be needed on three fronts simultaneously – demand, efficiency and funding. Less impact or emphasis on any one of them will require compensating action on the other two. There is nothing in the analysis undertaken for *Five Year Forward View* that suggests that continuing with a comprehensive tax-funded NHS is not "intrinsically un-doable". Instead *Five Year Forward View* suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, allied with the support of government and other partners.

4.6 At the North Tripartite Event on 4th November 2014, organised by NHS England, Monitor and the Trust Development Authority, there was clear message that *5 Year Forward View* requires a period of reflection but that this should be short. Delivery is expected from April 2015, with demonstrable congruence with our existing strategies and plans.

4.7 NHS Halton CCG is developing a Halton response to this NHS led strategic view. This will ensure that there is congruence with our 5 Year Commissioning Strategy, 2 Year Operational Plan, Better Care Fund and other initiatives that are shared with partners across the borough. The attached template (Appendix 1) takes the key statements made and actions suggested in *Five Year Forward View* to apply a "Halton lens" to enable comparisons to be made. Contributions to this document are invited from all our partners and will be actively sought through the Health Policy and Performance Board on 13th January 2015 and Health and Wellbeing Board on 14th January 2015. A final document will then return to the Governing Body on 5th February 2015. The Governing Body are invited to contribute to the development of this document as strategic decisions will need to be made following from *Five Year Forward View*, particularly in regard to new models of care.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 As stated above, *Five Year Forward View* requires action on three fronts – demand, efficiency and funding. There is no guarantee that a future government will commit additional resources to the NHS or match existing funding arrangements. It is therefore suggested that *Five Year Forward View* will need to be delivered within existing resources.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

NHS Halton CCG will work closely with the Children's Trust to commission services for children and young people and to meet statutory responsibilities in regard to safeguarding.

6.2 Employment, Learning & Skills in Halton

None as a result of this report.

6.3 A Healthy Halton

NHS Halton CCG is a key partner in this agenda.

6.4 A Safer Halton

None as a result of this report.

6.5 Halton's Urban Renewal

None as a result of this report.

7.0 RISK ANALYSIS

7.1 The greatest risk arising from *Five Year Forward View* is that the systemic, step changes that the document suggests will not be achieved. The delivery of *Five Year Forward View* needs collective and collaborative action across all sectors, organisations and communities who have links with the NHS as well as within the NHS itself.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 In the delivery of *Five Year Forward View* through our commissioning strategy and operational plans, NHS Halton CCG will be required to ensure that it is compliant with the duties upon public bodies under the Equality Act 2010.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Five Year Forward View, Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority, 23rd October 2014, www.england.nhs.uk/ourwork/futurenhs/.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
Chapter Two: What will the future look like? A new relationship with patients and communities		
Getting serious about prevention		
We have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments. We need a range of new approaches to improving health and wellbeing.	*Incentivising and supporting healthier behaviour* For all major health risks – including tobacco, alcohol, junk food and excess sugar - we will actively support comprehensive, hard-hitting and broad-based national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing, and product formulation. We will also use the substantial combined purchasing power of the NHS to reinforce these measures.	Halton supports additional actions to incentivise and support healthier behaviour. There is strong collaboration across organisations and sectors within the borough on these issues. We also influence national and local policy by working with other local authority areas across Cheshire and Merseyside through CHAMPS. Our Director of Public Health also engages with counterparts across the North West England through the North West Directors of Public Health and their change manifesto. Halton also supports Food Active (formerly Heart of Mersey) in national actions on labelling and product formulation. We are working with Drinkwise on influencing local licensing policy, Minimum Unit Pricing and with the industry locally to improve standards. Halton has a number of co-ordinated

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
		initiatives in place to make the night-time economy more vibrant, diverse and safer. These schemes include Purple Flag and Archangel. We work closely with Tobacco Free Futures to influence across the region and develop policy. Halton Borough Council is recruiting a new Environmental Health post which will work with local employers to address workforce health. We believe that there is more that we can do to help local employers improve the health and wellbeing of their workforce. As the lead agency, Halton Borough Council is co-ordinating and implementing local action and activity with take away outlets to increase awareness of healthier choices. We are developing targeted personal support around parenting programmes through our Children's Centres. We also have a number of initiatives that empower communities to act for themselves and for the population by influencing and improving health literacy.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	Local democratic leadership on public health Local Health and Wellbeing Boards to drive health improvement. English mayors and local government need to be granted enhanced powers to allow local democratic decisions on public health policy that go further and faster than prevailing national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health.	Halton has a strong and vibrant Health and Wellbeing Board. The Halton Health and Wellbeing Board has clear public health oriented priorities, that are shared across the participant organisations. The Halton Health and Wellbeing Board is already providing leadership, support and direction on alcohol, fast food, tobacco and other issues that affect physical and mental health. Local democratic leadership is also being provided though the Licensing Committee through encouraging the breathalysing of individuals entering licensed premises to assist licensees in refusing service and working on the late night levy. Supplementary planning guidance is also in place to allow the Planning Committee to limit take away outlets from opening near to schools and in clusters. Halton would welcome enhanced powers to allow local democratic decisions on public health policy to go further than prevailing national law, where appropriate.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	Targeted prevention Proactive primary care needs to be central to delivery of evidence-based intervention strategies. Over the next five years England will become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.	NHS Halton CCG was pivotal in the introduction of the impaired glucose regulation (IGR) programme for diabetes in Merseyside. As part of the development of this work there was correspondence with NICE who were developing their recommendations at the time. The IGR pathway is linked with the Health Check and Healthy Weight programmes. It is being systematised across all practices in the borough. An evaluation of the IGR programme will enable improvement and learning and identify opportunities to address any unwarranted variation. We would expect there is considerable alignment between the programme we have in place at the moment and the national programme. We recognise that targeted prevention is essential. We have in place or are developing evidence-based action in regard to dementia, hypertension, cardiovascular disease (CVD), cancer and respiratory conditions. We have identified that around 40% of our population have poor health outcomes, experience significant inequalities and access support

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
		late in the progression of their disease or condition. We believe that there is a significant opportunity to work differently to target prevention at this cohort of our population through working the voluntary sector and other organisations such as Cheshire Fire Service.
	NHS support to help people get and stay in employment There is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods – particularly in regard to mental health problems and musculoskeletal complaints. A new government-backed Fit for Work scheme starts in 2015. During the next Parliament we will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals while saving 'downstream' costs at the Department for Work and Pensions, if money can be reinvested across programmes.	We agree that the NHS has a greater role to play in supporting to help people get and stay in employment. We will investigate the implications of the Fit for Work scheme to see how we can maximise opportunities to help people get and stay in employment. We are already considering access to and maintenance of employment in a number of areas. For example, NHS Halton CCG is undertaking a redesign of MSK services, which will look to increase integration across the service and move from an activity based contract to outcomes based contract, these outcomes are expected to include a focus on maintaining and returning to work. Implementation of the Family Nurse Partnership will support young parents to

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
		build confidence and return to training and/or employment. Finally, our Community Wellbeing Practices have been working on supporting people back into work alongside existing organisations in the borough.
	Workplace health There is merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the support it offers its own 1.3 million staff to stay healthy, and serve as "health ambassadors" in their local communities.	As an employer, NHS Halton CCG provides incentives and practical support to enable staff to stay healthy and maintain their wellbeing. There are also opportunities for staff to act as "health ambassadors". OTHER NHS ORGANISATIONS? Halton Borough Council is recruiting a new Environmental Health post which will work with local employers to address workforce health. This role needs to be linked in with partners, including NHS partners, in the borough. We believe that there is more that we can do to help local employers improve the health and wellbeing of their workforce.
Empowering patients		
Personalised care will only happen when	*Improved information*	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'.	Improve the information to which people have access—not only clinical advice, but also information about their condition and history. Within five years, all citizens will be able to access their medical and care records (including in social care contexts) and share them with carers or others they choose.	NHS Halton CCG and Halton Borough Council, working with provider organisations, are developing a Health and Social Care Information Management and Technology (IM&T) Strategy that will enable citizens have access to their medical and care records.
	Support people to manage their own health Enable people to stay healthy, make informed choices of treatment, manage conditions and avoid complications. With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge.	In Halton we recognise that we need to create more opportunity to support people to manage their own health, as they are often 'experts by experience'. We are supporting the re-implementation of Expert Patient to support other initiatives. For example, NHS Halton CCG already commissions a comprehensive diabetes education programme. In conjunction with the Mersey Diabetes Network a further piece of work is being undertaken to further increase the number of people who access these programmes. We have also brought together our health and wellbeing services to ensure that they

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
		promote self-care and health literacy. We are also developing social marketing approaches to self-care. Finally, NHS Halton CCG already commissions a Care at the Chemist scheme to support self-care. The conditions covered by this scheme will be expanded. NHS Halton CCG is also exploring the role of community pharmacy and how pharmacies/pharmacists can support people to manage their own health. We recognise that we need to do more to target support to the 40% of our population who have the worst health outcomes. The voluntary sector and local community networks are vital in this for it is they who can support broadening health literacy, enhancing community resilience and awareness, and moving to asset based approaches.
	Increase the direct control patients have over the care that is provided to them Patients should have choice over where and how they receive care. We will introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex	Progress has already been made in Halton in regard to personalised budgets and direct payments. We would be interested in exploring the implications of IPC further and would also welcome the exploration of 'year of care' approaches.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation.	
Engaging communities		
We need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. Programmes like NHS Citizen point the way, but we also commit to four further actions to build on the energy and compassion that exists in communities across England.	*Better support for carers* We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – young carers and the carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities.	
	Creating new options for health-related volunteering Volunteers are crucial in both health and social care. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10%	NEEDS MORE BUT: The Expert Patients programme will be an ideal opportunity to increase the number of volunteers providing peer support and

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	reduction in their council tax bill, worth up to £200 a year. We support testing approaches like that, which could be extended to those who volunteer in hospitals and other parts of the NHS. The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff. For example, more than 1,000 "community first responders" have been recruited by Yorkshire Ambulance in more rural areas and trained in basic life support. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes. We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind, as well as better matching volunteers to the roles where they can add most value.	training to people with long term conditions. We also have a peer support programme for breastfeeding that provides a wide range of information, advice and support.
	Stronger partnerships with charitable and voluntary sector organisations The voluntary sector is often better able to	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	reach underserved groups, and is a source of advice for commissioners on particular needs. We will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible.	
	The NHS as a local employer The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. NHS employers also have the opportunity to be more creative in offering supported job opportunities to 'experts by	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	experience' such as people with learning disabilities who can help drive the kind of change in culture and services that the Winterbourne View scandal so graphically demonstrated is needed.	
The NHS as a social movement		
None of these initiatives and commitments by themselves will be the difference between success and failure over the next five years. But collectively and cumulatively they and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and—as a by-product—help moderate rising demands on the NHS.	Rather than being seen as the 'nice to haves' and the 'discretionary extras', our conviction is that these sort of partnerships and initiatives are in fact precisely the sort of 'slow burn, high impact' actions that are now essential. They in turn need to be matched by equally radical action to transform the way NHS care is provided.	
Chapter Three: What will the future look like? New models of care		
Emerging models		
The traditional divide between primary care, community services, and hospitals is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three. Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the	• Increasingly we need to manage systems – networks of care – not just organisations. • Out-of-hospital care needs to become a much larger part of what the NHS does. Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health	MSK? NHS Halton CCG has been developing a Strategy for General Practice Services as well as reviewing community nursing and out-of-hospital care.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care.	addressed at the same time. • We should learn much faster from the best examples, not just from within the UK but internationally. • And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money. We intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England. However England is too diverse – both in its population and its current health services – to pretend that a single new model of care should apply everywhere. But that doesn't mean there are an infinite number of new care models. While the answer is not one-size-fits-all, nor is it simply to let 'a thousand flowers bloom'. Our approach will be to identify the characteristics of similar health communities across England, and then jointly work with them to consider which of the new options signalled by this Forward View constitute viable ways forward for their local health and care services over the next five years and beyond.	NHS Halton CCG has expressed an interest in participating in the HOPE exchange programme to increase the sharing of best practice internationally.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
A new deal for primary care		
General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals.	Over the next five years we will invest more in primary care. Steps we will take include: • Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas. • Give GP-led Clinical Commissioning Groups (CCGs) more influence over • the wider NHS budget, enabling a shift in investment from acute to primary and community services. • Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services. • Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off	Suspending the PMS review is clearly a key issue if this is to be made reality for Halton. Within the implementation of co-commissioning of primary care, NHS Halton CCG has the opportunity to support and help shape the new deal for primary care. With robust governance arrangements in place, member practices input into this will be essential and will help shape future local models. There are clearly risks over funding and having the management capacity to do this for Halton CCG.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	potential returners. • Expand funding to upgrade primary care infrastructure and scope of services. • Work with CCGs and others to design new incentives to encourage new • GPs and practices to provide care in under-doctored areas to tackle health inequalities. • Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.	It does depend on more money being made available for primary care – as yet no formula developed to create fare share targets for pCrimary care allocations. Will Halton get any additional resources to make this a reality?
New care model – Multispecialty Community Providers		
Primary care is entering the next stage of its evolution. The traditional model has been evolving. Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer	To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form – either as federations, networks or single organisations. These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients. • As larger group practices they could in future begin employing consultants or take them on as	NHS Halton CCG and partners are working on a strategy for general practice services and a new model for out of hospital care. There has been some initial thinking about models of care that wrap services around groups of practices. This could be the basis of a local MCP type model, although NHS Halton CCG is keen to focus on a model of Multispecialty Community Provision with existing partners as supposed to be focused on creating a Multispecialty Community Provider.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.	partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff. • These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings. • They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy. • GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries. • They could in time take on delegated responsibility for managing the health service budget for their registered patients.	NHS Halton CCG has already indicated that the Urgent Care Centres could expand their offering to pick up more out-of-hospital care. There is a challenge as to whether this would increase service costs without rationalisation of acute hospital facilities. The implementation of the Strategy for General Practice Services in Halton will include exploring further partnerships with the voluntary and community sector and community pharmacy.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers. • These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours. We will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure.	
New care model – Primary and Acute Care Systems (PACS)		
A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures. We will now permit a new variant of integrate care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services. The leadership to bring about	• In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to	It is difficult to see how, with two acute providers, a newly designated community FT and an established mental health FT this model would work in Halton. Implementation would be problematic and it is unclear what safeguards would be in place for out of hospital care, without significantly changing the current PbR contractual system.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.	kickstart the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways. • In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital. • At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries. PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small	It is unlikely that the developing MCP model in Halton would be in a position to take over a DGH or indeed aspires to do so. The most radical model would need to legislation - if all GPs were part of this it could be indistinguishable from the CCG and conflicts of interest may arise. Halton's local environment does not lend itself to a PACS model.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.	
New care model – urgent and emergency care networks		
Over the next five years, the NHS will do far better at organising and simplifying the system.	This will mean: • Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists. • Developing networks of linked hospitals that ensure patients with the most serious needs get to	NHS Halton CCG is leading a Mid-Mersey group examining the options for stroke services, including the location of hyper-

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured. • Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes. • Proper funding and integration of mental health crisis services, including liaison psychiatry. • A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully. • New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible.	acute services at a single hospital site. How will this be funded given very low levels of NHS growth funding?
New care model – viable smaller hospitals		
England already has one of the more centralised hospital models amongst advanced health systems. It is right that these (smaller district general) hospitals should not be providing complex acute services where there is evidence that high	We will now take three sets of actions. First, NHS England and Monitor will work together to consider whether any adjustments are needed to the NHS payment regime to reflect the costs of	Both our acute providers are considered to have hospitals that are “small”. Changes to the system could pose a financial risk to NHS Halton CCG.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
volumes are associated with high quality. Some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country. In some case there may be a need to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities.	delivering safe and efficient services for smaller providers relative to larger ones. Second, building on the earlier work of Monitor looking at the costs of running smaller hospitals, and on the Royal College of Physicians Future Hospitals initiative, we will work with those hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures. Third, we will create new organisational models for smaller acute hospitals that enable them to gain the benefits of scale without necessarily having to centralise services. Building on the recommendations of the forthcoming Dalton Review, we intend to promote at least three new models: • In one model, a local acute hospital might share management either of the whole institution or of their 'back office' with other similar hospitals not necessarily located in their immediate vicinity. • In another new model, a smaller local hospital might have some of its services on a site provided by	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	another specialised provider. • And as indicated in the PACS model above, a further new option is that a local acute hospital and its local primary and community services could form an integrated provider.	
New care model - specialised care		
In some services there is a compelling case for greater concentration of care. In these services there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur.	In services where the relationship between quality and patient volumes is strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews. We will also look to these specialised providers to develop networks of services over geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets.	
New care model – modern maternity services		
Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade, and are at their highest in 40 years. Recent research shows that for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with	To ensure maternity services develop in a safe, responsive and efficient manner, in addition to other actions underway – including increasing midwife numbers - we will: • Commission a review of future models for maternity units, to report	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
fewer interventions. Four out of five women live within a 30 minute drive of both an obstetric unit and a midwife-led unit, but research by the Women's Institute and the National Childbirth Trust suggests that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so.	by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS. • Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them. • As a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.	
New care model – enhanced health in care homes		
One in six people aged 85 or over are living permanently in a care home. Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.	In partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, we will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost.	
How will we support the co-design and implementation of these new care models?		

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
Some parts of the country will be able to continue commissioning and providing high quality and affordable health services using their current care models, and without any adaptation along the lines described above. However, previous versions of local 'five year plans' by provider trusts and CCGs suggest that many areas will need to consider new options if they are to square the circle between the desire to improve quality, respond to rising patient volumes, and live within the expected local funding. In some places, including major conurbations, we therefore expect several of these alternative models to evolve in parallel. In other geographies it may make sense for local communities to discuss convergence of care models for the future. This will require a new perspective where leaders look beyond their individual organisations' interests and towards the future development of whole health care economies - and are rewarded for doing so. It will also require a new type of partnership between national bodies and local leaders. That is because to succeed in designing and implementing these new care models, the NHS locally will need national bodies	We will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop: • Detailed prototyping of each of the new care models described above, together with any others that may be proposed that offer the potential to deliver the necessary transformation - in each case identifying current exemplars, potential benefits, risks and transition costs. • A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models, promote peer learning with similar areas, and allow joint intervention in health economies that are furthest from where they need to be. • National and regional expertise and support to implement care model change rapidly and at scale. The NHS is currently spending several hundred million pounds on bodies that directly or indirectly could	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
jointly to exercise discretion in the application of their payment rules, regulatory approaches, staffing models and other policies, as well as possibly providing technical and transitional support.	support this work, but the way in which improvement and clinical engagement happens can be fragmented and unfocused. We will therefore create greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks. • National flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models. • Design of a model to help pump-prime and 'fast track' a cross-section of the new care models. We will back the plans likely to have the greatest impact for patients, so that by the end of the next Parliament the benefits and costs of the new approaches are clearly demonstrable, allowing informed decisions about future investment as the economy improves. This pump-priming model could also unlock assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	use accrued savings on their balance sheets to help local service transformation.	
Chapter Four: How will we get there?		
We will back diverse solutions and local leadership		
Many CCGs are now harnessing clinical insight and energy to drive change in their local health systems in a way that frankly has not been achievable before now. We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government. There is no appetite for a wholesale structural reorganisation.	NHS England intends progressively to offer CCGs more influence over the total NHS budget for their local populations, ranging from primary to specialised care. Joint commissioning models will include Integrated Personal Commissioning as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards. Changes in local organisational configurations should arise only from local work to develop new care models or in response to clear local failure and the resulting implementation of special measures.	
We will provide aligned national NHS leadership		
NHS England, Monitor, the NHS Trust Development Authority, the Care	We intend to develop our shared work:	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
Quality Commission, Health Education England, NICE and Public Health England have distinctive national duties laid on them by statute, and rightly so. However in their individual work with the local NHS there are various ways in which more action in concert would improve the impact and reduce the burden on frontline services.	• Through a combined work programme to *support the development of new local care models.* • Monitor, TDA and NHS England will work together to create greater alignment between their respective *local assessment, reporting and intervention regimes* for Foundation Trusts, NHS trusts, and CCGs, complementing the work of CQC and HEE. • NHS England will also develop a new risk-based CCG assurance regime that will lighten the quarterly assurance reporting burden from high performing CCGs, while setting out a new 'special measures' support regime for those that are struggling. • Using existing flexibilities and discretion, we will deploy national regulatory, pricing and funding regimes to support change in specific local areas that is in the interest of patients. • The key NHS oversight organisations will come together regionally and nationally to *share intelligence, agree action and*	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	monitor overall assurance on quality. The National Quality Board provides such a forum, and we intend to reenergise it.	
We will support a modern workforce		
We need a workforce with the right numbers, skills, values and behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important. Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. These increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. We have yet to see a significant shift from acute to community sector based working – just a 0.6% increase in the numbers of nurses working in the community over the past ten years.	By supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them. Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care.	
Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce.	HEE will work with its statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it. This work will be taken forward through the HEE's leadership of the implementation of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can 'future proof' the NHS against the challenges to come. More generally, over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage recruitment and retention in parts of the country and in	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	occupations where vacancies are high.	
We will exploit the information revolution		
Progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative. The NHS is not yet exploiting its comparative advantage as a population-focused national service. The NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense - at times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme. The result has been systems that don't talk to each other, and a failure to harness the shared benefits that come from interoperable systems.	In future we intend to take a different approach. Nationally we will focus on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards. A National Information Board has been Established. The NIB will publish a set of 'road maps' laying out who will do what to transform digital care. Key elements will include: • Comprehensive transparency of performance data – including the results of treatment and what patients and carers say – to help health professionals see how they are performing compared to others and improve; to help patients make informed choices; and to help CCGs and NHS England commission the best quality care. • An expanding set of NHS	NHS Halton CCG and Halton Borough Council are currently developing a joint health and social care strategy which will cover all the points listed in this section.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion. • Fully interoperable electronic health records so that patients' records are largely paperless. Patients will have full access to these records, and be able to write into them. They will retain the right to opt out of their record being shared electronically. The NHS number, for safety and efficiency reasons, will be used in all settings, including social care. • Family doctor appointments and electronic and repeat prescribing available routinely on-line everywhere. • Bringing together hospital, GP, administrative and audit data to support the quality improvement, research, and the identification of patients who most need health and social care support. Individuals will be able to opt out of their data being used in this way.	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	• Technology – including smartphones - can be a great leveller and, contrary to some perceptions, many older people use the internet. However, we will take steps to ensure that we build the capacity of all citizens to access information, and train our staff so that they are able to support those who are unable or unwilling to use new technologies.	
We will accelerate useful health innovation		
Research is vital in providing the evidence we need to transform services and improve outcomes.	We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine. Steps we will take to speed innovation in new treatments and diagnostics include: • The NHS has the opportunity radically to cut the costs of conducting Randomised Controlled Trials (RCTs), not only by	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	streamlining approval processes but also by harnessing clinical technology. We will support the rollout of the Clinical Practice Research Datalink, and efforts to enable its use to support observational studies and quicker lower cost RCTs embedded within routine general practice and clinical care. • In some cases it will be hard to test new treatment approaches using RCTs because the populations affected are too small. NHS England already has a £15m a year programme, administered by NICE, now called "commissioning through evaluation" which examines real world clinical evidence in the absence of full trial data. At a time when NHS funding is constrained it would be difficult to justify a further major diversion of resources from proven care to treatments of unknown cost effectiveness. However, we will explore how to expand this programme and the Early Access to Medicines programme in future years. It will be easier if the costs of	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	doing so can be supported by those manufacturers who would like their products evaluated in this way. • A smaller proportion of new devices and equipment go through NICE's assessment process than do pharmaceuticals. We will work with NICE to expand work on devices and equipment and to support the best approach to rolling out high value innovations—for example, operational pilots to generate evidence on the real world financial and operational impact on services—while decommissioning outmoded legacy technologies and treatments to help pay for them. • The Department of Health-initiated Cancer Drugs Fund has expanded access to new cancer medicines. We expect over the next year to consult on a new approach to converging its assessment and prioritisation processes with a revised approach from NICE. • The average time it takes to translate a discovery into clinical practice is however often too slow.	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	So as well as a commitment to research, we are committed to accelerating the quicker adoption of cost-effective innovation - both medicines and medtech. We will explore with partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this.	
Accelerating innovation in new ways of delivering care		
We have an unexploited opportunity to *combine* different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed 'combinatorial innovation'. The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system,	Over the next five years we intend to: • Develop a small number of 'test bed' sites alongside our Academic Health Science Networks and Centres. They would serve as real world sites for 'combinatorial' innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes. Innovators from the UK and internationally will be able to bid to have their proposed discovery or innovation deployed and tested in these sites. • Working with NIHR and the Department of Health we will expand NHS operational research, RCT capability and other methods to promote more rigorous ways of	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been 'piloted' without other needed components. Even where 'whole system' innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight.	answering high impact questions in health services redesign. An example of the sort of question that might be tested: how best to evolve GP out of hours and NHS 111 services so as to improve patient understanding of where and when to seek care, while improving clinical outcomes and ensuring the most appropriate use of ambulance and A&E services. Further work will also be undertaken on behavioural 'nudge' type policies in health care. • We will explore the development of health and care 'new towns'. England's population is projected to increase by about 3 to 4 million by 2020. New town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing. The health campus already planned for Watford is one example of this.	
We will drive efficiency and productive investment		

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
It has previously been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of a) growing demand, b) no further annual efficiencies, and c) flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two.	*Demand* On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years. *Efficiency* Over the long run, NHS efficiency gains have been estimated by the Office for Budget Responsibility at around 0.8% net annually. Given the pressures on the public finances and the opportunities in front of us, 0.8% a year will not be adequate, and in recent years the NHS has done more than twice as well as this. A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff. Our ambition, however, would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. This would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. It would require investment in new care models and would be achieved by a combination of "catch up" (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working of the sort laid out in chapters three and four are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the 'right care, at the right time, in the right setting,	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	from the right caregiver'. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years. *Funding* NHS spending has been protected over the past five years, and this has helped sustain services. However, pressures are building. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income. Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way. • In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity	A key question for Halton is how the allocation formula may impact on future funding growth. Halton is likely to get a bottom range of uplift for CCGs, although the inclusion of primary care (formula still be developed) and some specialised services in CCG commissioning responsibilities may help reduce over target for Halton.

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion. • In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion. • In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21. Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in the analysis above suggests that continuing with a comprehensive tax-	

What the 5 Year Forward View says	What action the 5 Year Forward View suggests	What is the Halton approach?
	funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them.	

REPORT TO: Health and Wellbeing Board

DATE: 14th January 2015

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton Suicide Prevention Strategy 2015-20

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the final draft of the Halton Suicide Prevention Strategy 2015-20

RECOMMENDATION: That

1. **the Board note the contents of the report; and**

2. **the Board supports the strategy outcomes, objectives, and actions**

2.0 SUPPORTING INFORMATION

2.1 Suicide is a major public health issue, and a major cause of years of life lost. Each suicide in Halton is an individual tragedy and a terrible loss to our local families and communities. The numbers of people who take their own life in Halton each year are low however those ending their own life should be viewed as the tip of an iceberg and locally levels of distress will be much higher.

2.2. In times of economic and employment insecurity rates of suicide often increase. This trend has been observed nationally following the 2008 financial crisis when after a decade of falling suicide rates have started to rise. Although it is too early to say whether this national trend is being observed locally it demonstrates the need for continuing vigilance and action and highlights why a new suicide prevention strategy for Halton is required.

Halton Suicide Prevention Strategy 2015-20

2.3 Suicide is not inevitable and can be prevented. The Halton Suicide prevention strategy (Appendix A) was written in partnership and sets out evidence-based actions, based upon national policy, research and local insight, to prevent suicide and support those bereaved or affected by suicide in Halton.

2.4 This strategy is supported by a detailed action plan outlining actions, responsible leads, timescales and outcomes to be achieved (Appendix B).

The plan will be monitored by the Halton Suicide Prevention Partnership, and outcomes reported to the Safer Halton Partnership, Health and Well Being Board and all other relevant bodies.

2.5 The strategy includes background information which sets out the policy context in which the strategy has been developed, considers the factors that influence why a person may take their own life and reviews the evidence on suicide prevention, outlines what we know about suicide in Halton and sets out actions to reduce the risk of suicide in Halton.

2.6 The reasons why people may take their own life are complex. The many factors that influence whether someone may feel like taking their own life can be divided into *Risk factors* which increase the likelihood of suicidal behaviour and *Protective factors*: which reduce the likelihood of suicidal behaviour through improving a person's ability to cope with difficult circumstances. The suicide prevention initiatives outlined within this strategy focus on increasing protective factors and reducing risk factors for suicide within Halton.

2.7 During the last 5 years in Halton there has been on average 12 suicides per year. Each year an annual suicide audit is undertaken within Halton. Completing the suicide audit improves our understanding of those most at risk of suicide and allows us to target suicide prevention strategies appropriately. Although most suicides in Halton take place in the home, we also have a known suicide 'hotspot' where repeat suicide attempts take place – the Silver Jubilee Bridge (Runcorn and Widnes Bridge). In addition work has recently commenced on a new Mersey Gateway Bridge with an opening date of autumn 2017 expected for the new crossing.

Suicide Prevention Strategy - vision, areas for action outcomes and objectives

2.8 **Our vision** is for a community where:

- We understand the root causes of suicide through effective collection and analysis of key information
- We have created a "listening" culture where it is okay to talk about feelings and emotional wellbeing
- We pro-actively communicate so that those directly and indirectly impacted by suicide know what support is there for them
- We provide readily accessible support through services working in partnership with other agencies and organisations
- We take positive, co-ordinated action to tackle prioritised root cause issues in order to prevent suicides

2.9 In order to achieve this vision and based upon national policy, research evidence and local insight 6 areas for action have been identified and agreed. All 6 areas for action have equal priority.

1. Improve the mental health and wellbeing of Halton residents
2. Promote the early identification and support of people feeling suicidal
3. Reduce the risk of suicide in known high risk groups
4. Reduce access to the means of suicide

5. Provide better information and support to those bereaved or affected by suicide
6. Support research, data collection and monitoring

2.10 Based upon national evidence and local intelligence the groups identified as being at high risk of suicide in Halton include:

- Young and middle aged men (for the period 2011-13 80% of suicide deaths were among men).
- People with mental health problems, including those in the care of mental health services (for the period 2011-13 57% of suicides in Halton were by people who had a known mental health problem. Of these 23% were known to mental health services).

- People with a history of self-harm (27% of people who died by suicide in Halton for the period 2011-13 had a recorded history of self-harm).

- People in contact with the criminal justice system (17% of those who died by suicide in Halton for the period 2011-13 had been in contact with the police in the period prior to their death).

- People who misuse drugs or alcohol (50% of those who died by suicide in Halton for the period 2011-13 were known to have a misusing alcohol or drugs at the time of death).

- Children and young people
- Older adults
- Survivors of abuse and violence including sexual abuse
- Veterans
- People living with long-term physical health conditions
- People who are especially vulnerable due to social and economic circumstances (for example due to debt, housing problems or unemployment)

- Lesbian, gay, bisexual and transgender people

2.11 Key actions to prevent suicides in Halton identified within the strategy include:

- Developing a local multi-agency suicide awareness campaign plan
- Developing a local training plan to deliver suicide awareness training for community members, local community groups and key professionals who interact with known groups at high risk of suicide
- Ensuring those identified as being at risk of suicide can access immediate support
- Reducing access to the means of suicide locally
- Continued support of Operation Emblem (a "street triage" service where a police officer and Community Psychiatric Nurse (CPN) attend incidents where concerns for safety are identified).
- Commissioning a postvention service to ensure we have effective local responses to the aftermath of a suicide
- Continuing to undertake an annual suicide audit

2.12 The ***Halton Suicide Prevention Partnership*** will monitor outcomes related to high level indicators included within the Public Health and NHS Outcomes Framework this includes:

- the suicide rate
- self-harm rates
- excess under 75 mortality in adults with a serious mental illness

2.13 The Halton suicide prevention strategy has been developed by a multi-agency group with representation from both Adult and Children's Services at the Council, the Police, service providers, the voluntary and community sector and other key partners.

Halton Suicide Prevention Partnership:

HBC - Public Health	HBC – Elected Members
Halton Clinical Commissioning Group	Cheshire Police
HBC – Children's Commissioners	Cheshire Fire
HBC – Emergency Planning	Halton Housing Trust
Riverside College	Crime Reduction Initiative (CRI)
5 Borough Partnership NHS Foundation Trust	HBC - Early intervention team
HBC – Health Improvement Team	Halton Citizens Advice Bureau
MIND	Age UK
Samaritans	HBC – Adult social care

2.14 The strategy was informed by the outcomes of a public consultation event and has been informed and influenced by both local need and national policy. A formal public consultation is also being undertaken to enable local people to provide feedback and insight to the final version of the strategy and action plan, although both will be kept under regular review to ensure that they are still relevant and meeting the needs of local people.

2.15 The strategy will be presented to the following boards for further input and discussion:

- Safer PPB
- Children's Trust Board
- Halton Clinical Commissioning Group Executive Board
- CAMHS Board
- HBC Executive Board

3.0 POLICY IMPLICATIONS

3.1 The Strategy will set the context for partnership working to prevent suicides and support those bereaved or affected by suicide in Halton. Suicide prevention is a national, regional and local priority. In 2012 the Government published its all-age suicide prevention strategy *Preventing Suicide in England: A cross-government outcomes strategy to save lives* which has informed the development of our local strategy. Locally the *Halton Health and Wellbeing Strategy 2012- 2015* identified the prevention and early detection of

mental health conditions as one of its 5 priority areas for action. Suicide prevention activity is identified as a key action towards this priority.

4.0 OTHER/FINANCIAL IMPLICATIONS

4.1 The actions identified within the strategy will be delivered through existing resources identified within each partner's budget. Some service redesign or an innovative approach to service delivery will be required to better meet the needs of local people.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children and Young People in Halton

Children and young people are identified as a high risk group within the strategy. The strategy outlines actions aimed at promoting the mental health and wellbeing of children and young people in Halton, preventing bullying within our local schools, ensuing the early identification and support of children and young people suffering from emotional, behavioural or mental health difficulties, raising awareness of the signs of suicide among staff who work with children and young people in Halton, and ensuring support is available in a time of crisis.

5.2 Employment, Learning and Skills in Halton

Suicide is a major public health issue, and a major cause of years of life lost. The economic impact of suicides is also high in terms of lost earnings and potential. It has been estimated that the average cost of a working age adult in England ending their own is £1.67million.

5.3 A Healthy Halton

This strategy forms a central strand of meeting the commitments to prevent suicide and support those bereaved or affected by suicide locally.

5.4 A Safer Halton

Suicide prevention is an important as aspect of promoting community safety. Locally we have a known suicide hot spot in the Silver Jubilee Bridge (the Runcorn and Widnes Bridge). Responding to suicide threats and attempts places a considerable burden on the time and resources of partners locally. It is also recognized that the police are often the first responders to a suicide attempt. The strategy outlines actions related to promoting community safety which include the continued support and strengthening of Operation Emblem (a "street triage" service where a police officer and Community Psychiatric Nurse (CPN) attend incidents where concerns for safety are identified), reviewing best practice evidence related to reducing the risk of suicide at the Silver Jubilee Bridge, advising on suicide prevention interventions planned for the new Mersey Gateway Bridge and other large new developments within the Borough.

5.5 Halton's Urban Renewal

As part of the strategy, there is a commitment to reduce access to the means of suicide in the planning of new large developments within the Borough.

6.0 RISK ANALYSIS

The key risk is a failure to reduce the suicides among Halton residents. This risk can be mitigated through the regular review and reporting of progress and the development of appropriate interventions where under-performance may occur.

7.0 EQUALITY AND DIVERSITY ISSUES

The Strategy specifically aims to meet the needs of all residents in Halton to prevent suicides and ensure the adequate support of those bereaved or affected by suicide locally.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officer
A) Draft Suicide Prevention Strategy 2015-2020	HBC website	Dr Elspeth Anwar
B) Draft Suicide Prevention Strategy Action Plan, 2015-16	HBC website	Dr Elspeth Anwar

Halton Suicide Prevention Strategy

2015-20

Foreword

Each suicide in Halton is an individual tragedy. In addition each suicide has a devastating ripple effect. Bereavement following a suicide is like no other bereavement, and can have devastating impacts on those who are left behind: families, friends and wider communities.

We know life got harder for many people following the recent financial crisis. Nationally after a decade of falling suicide rates suicide rates following the 2008 financial crisis there has been an increase in the number of people choosing to die by suicide. Although it is too early to say whether this national trend is being observed locally it demonstrates the need for continuing vigilance and action and highlights why a new suicide prevention strategy for Halton is required.

Suicides are not inevitable and can be prevented if the signs are recognised and support provided. This 5 year strategy aims to reduce suicides in Halton by better supporting those most at risk and providing information for those affected by a loved one's suicide.

No one organisation is able to address all the factors to reduce suicide risk and prevent suicides. That is why this strategy has been developed in partnership. The strategy sets out evidence-based actions, based upon national policy, research and local insight, to prevent suicide and support those bereaved or affected by suicide in Halton. The strategy is supported by an action plan which outlines exactly how, by whom and when the agreed actions will be undertaken and the outcomes we hope to achieve. The ***Halton Suicide Prevention Partnership*** will meet quarterly to monitor the implementation of this strategy.

Eileen O'Meara, Director of Public Health, Halton Borough Council

I fully endorse this strategy. One death to suicide in Halton is one too many – Each and every suicide is a tragedy which has a devastating effect on families, friends, colleagues and the wider community. This strategy aims to make suicide prevention everyone's business. Contrary to the commonly held belief that suicide is inevitable, this strategy points to the many ways through working together we can make a difference. We firmly believe that suicide can be prevented and will work hard to ensure that people who are feeling suicidal in Halton can get support when they need it, how they need it and where they need it.

Cllr Marie Wright, Halton Borough Council's portfolio holder for Health and Wellbeing

Contents

Introduction

Suicide[1] is a major public health issue, and a major cause of years of life lost. Each suicide in Halton is an individual tragedy and a terrible loss to local families and communities. The economic impact of suicides is also high. It has been estimated that the average cost of a working age adult in England ending their own is £1.67million[2].

In times of economic and employment insecurity rates of suicide often increase. This trend has been observed nationally following the 2008 financial crisis when after a decade of falling suicide rates suicide rates have risen. Locally suicide rates have also increased during 2011 to 2013 compared to previous years. Although the numbers of people who take their own life in Halton each year are low it is important to recognise those ending their own life are the tip of an iceberg and locally levels of distress and suicide attempts are much higher. The recent increase in the number of suicides locally demonstrates the need for continuing vigilance and action and highlights why a new suicide prevention strategy for Halton is required.

The challenge of suicide prevention

Suicide is not inevitable and can be prevented. Suicide is often the end point of a complex history of risk factors and events and for many people it is the combination of factors which is important rather than one single factor. We know that an inclusive society that avoids marginalising individuals and which supports people at times of personal crisis will help prevent suicides. We also know that evidence-based interventions exist that if implemented can reduce the risk of suicide.

This strategy was written in partnership and sets out evidence-based actions, based upon national policy, research and local insight, to prevent suicide and support those bereaved or affected by suicide in Halton. The strategy is supported by an action plan which outlines exactly how, by whom and when the agreed actions will be undertaken and the outcomes we hope to achieve.

Preventing suicides is a complex and challenging issue, but there are effective solutions for many, if not most of the individual factors which contribute towards the risk of suicide.

Scope of this strategy

We have to be clear about the scope of the strategy - it is specifically about the prevention of suicide and supporting those bereaved or affected by suicide in Halton. We recognise that suicide prevention starts with better mental health for all. Therefore this strategy is integrally linked to the *Halton Mental Health and Wellbeing Commissioning Strategy 2013-18* which aims to promote mental health and wellbeing, ensure the early diagnosis and treatment of people with a mental illness and support their recovery.

[1] Suicide is used in this document to mean a deliberate act that intentionally ends one's life.
[2] Knapp, M., McDaid, D., & Parsonage, M. (2011). Mental health promotion and mental illness prevention: the economic case. London: Department of Health. Available from: http://eprints.lse.ac.uk/32311/1/Knapp_et_al__MHPP_The_Economic_Case.pdf

Vision

Our vision is for a community where:

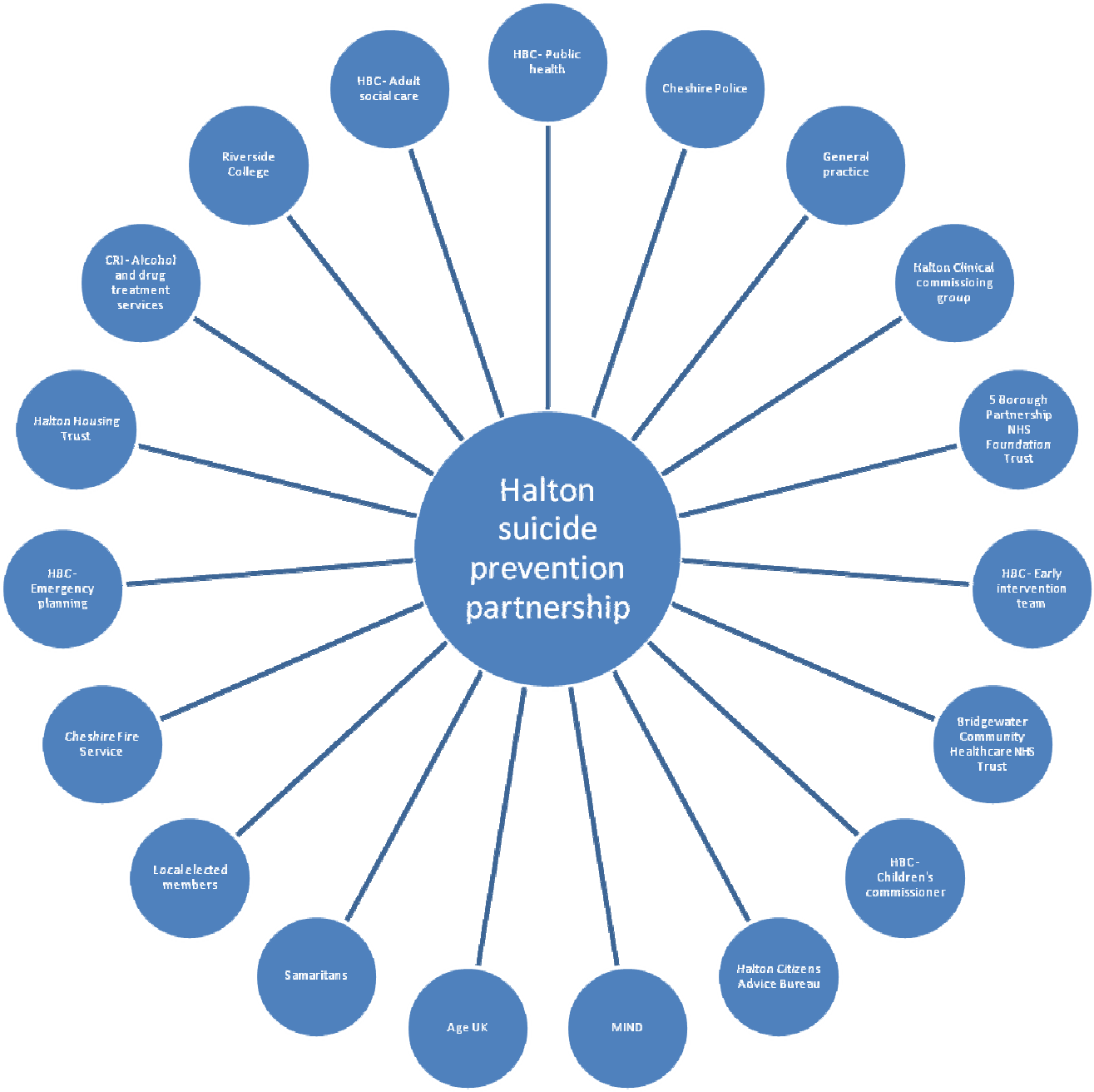
- We understand the root causes of suicide through effective collection and analysis of key information
- We have created a "listening" culture where it is okay to talk about feelings and emotional wellbeing
- We pro-actively communicate so that those directly and indirectly impacted by suicide know what support is there for them
- We provide readily accessible support through services working in partnership with other agencies and organisations
- We take positive, co-ordinated action to tackle prioritised root cause issues in order to prevent suicides

The Strategy Development Process

Halton suicide prevention partnership

No one organisation is able to address all the factors to reduce suicide risk and prevent suicides. Therefore collaborative working is vital for effective suicide prevention. This strategy has been written in collaboration with all partners agreeing the vision and areas for action. The partners involved in drafting this strategy are shown in Figure 1. The ***Halton Suicide Prevention Partnership*** will meet quarterly to monitor the implementation of this strategy.

Figure 1: Halton suicide prevention partnership



Strategy consultation and engagement

Consultation with key professionals and the public has been vital in developing this strategy. At an early stage a suicide prevention strategy event for professionals with an interest in suicide prevention was held. This event was very well attended. Professionals engaged in meaningful discussions and feedback was received related to:

- Who the high risk groups for suicide are locally
- The actions we should be taking to reduce the risk of suicide among these identified at risk groups
- how we can reduce access to the means of suicide locally
- how we can support those bereaved or affected by suicide locally

This feedback was utilised in the development of the areas for action and action plan.

Consultation with the local community was also undertaken through partners involved in the suicide prevention partnership. A questionnaire was developed and made available both on-line and in paper based format. This allowed feedback to be received from the local community related to preventing suicides and better supporting those bereaved or affected by suicide locally.

The policy context for suicide prevention

Suicide prevention is a national, regional and local priority. The recommendations and actions within this strategy are informed by the national, regional and local policy context, as well as being influenced by local knowledge and insight.

National policy and guidance

In 2012 the Government published its all-age suicide prevention strategy *Preventing Suicide in England: A cross-government outcomes strategy to save lives*[3]. The new strategy reaffirms the importance of suicide prevention in improving the health and wellbeing of the nation. The strategy outlines effective interventions and resources to support local action. One of the main changes from the previous national strategy is the greater prominence on measures to support families – both those who are worried that a love one is at risk and those having to cope with aftermath of a suicide.

Preventing Suicide in England has two leading objectives:

- A reduction in the suicide rate in the general population in England
- Better support for those bereaved or affected by suicide

The strategy also outlines six key areas for action to achieve the objectives:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

Suicide prevention starts with better mental health for all. Therefore the Government advises that the new national suicide prevention strategy should be read alongside the *No health without mental health*[4] and *Healthy Lives, Healthy People*[5] which both include actions to improve the mental health of the population as a whole which will in turn support a general reduction in suicides.

Regional policy and guidance

At a regional level Halton is part of the Cheshire and Merseyside Suicide Reduction Network. The network was established in 2008, to seek greater co-ordination of responses to, and understanding of, patterns of suicide in the Cheshire and Merseyside region and the development of whole system approaches to reducing suicide. The Network has held a number of summits to share good practice and to consider the key issues we can work on at a regional level and collaboratively to overcome.

[3] Preventing Suicide in England: A cross-government outcomes strategy to save lives available from: http://tinyurl.com/kntvtkw
[4] No health without mental health Strategy available from: http://tinyurl.com/ptpkpsx
No health without mental health Implementation framework available from: http://tinyurl.com/cu78rtu
[5] Healthy Lives, Healthy People available from: http://tinyurl.com/ptpkpsx

The Cheshire and Merseyside Suicide Reduction Network is currently developing a regional suicide prevention strategy. Locally the Halton suicide prevention partnership will contribute towards the development of the regional strategy to ensure alignment with our local strategy.

The regional group has developed a Suicide reduction action plan (S-RAP) based upon the actions outlined within the national strategy. The S-RAP is designed to be a template to be adapted locally and has formed the basis of the action plan developed to support the implementation of this strategy.

Local policy and guidance

Halton Health and Wellbeing Strategy 2012- 2015 identified the prevention and early detection of mental health conditions as one of its 5 priority areas for action. Suicide prevention activity is identified as a key action towards this priority.

In order to improve the mental health and wellbeing of people in Halton a *Mental Health and Wellbeing Commissioning Strategy 2013-18* and delivery plan has been developed. This strategy sets out key objectives and priorities across the life-course to improve mental health in the Borough.

Many of the identified actions within the *Mental Health and Wellbeing Commissioning Strategy* will have a direct impact on reducing the risk of suicides in Halton. We have therefore ensured that this strategy is integrally linked to the *Mental Health and Wellbeing Commissioning Strategy* and delivery plan.

Why do people take their own lives?

The reasons why people may take their own life are very complex. The many factors that influence whether someone may feel like taking their own life can be divided into:

- *Risk factors*: increase the likelihood of suicidal behaviour;
- *Protective factors*: reduce the likelihood of suicidal behaviour through improving a person's ability to cope with difficult circumstances.

Risk and *Protective factors* are often at opposite ends of the same continuum. For example, social isolation (R*isk factor*) and social connectedness (*Protective factor*) are at either extremes of a person's social support network. Examples of risk and protective factors for suicide are outlined in Table 1.

Table 1: Example of risks and protective factors for suicide[6]

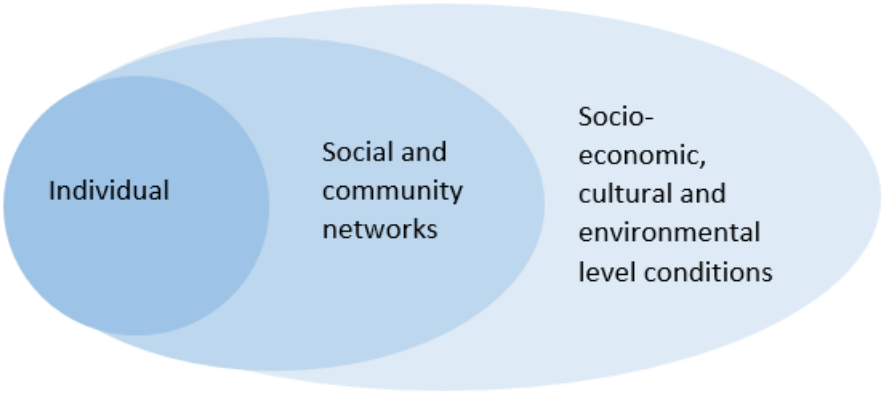
	Risk factors for suicide	Protective factors for suicide
Individual	• Gender (especially male gender) • Long-term conditions • Alcohol or substance misuse problem • Low self esteem • Little sense of control over life • Hopelessness • Poor coping skills	• Good mental health • Good physical health • No alcohol or substance misuse problem • Positive sense of self • Sense of control over life • Positive outlook • Good coping skills
Social and community	• Social isolation • Family dispute • Separation and loss • Peer rejection • Family history of suicide	• Social connectedness • Good family support • Well supported • Good social relationships • No family history of suicide
Socio-economic, cultural and environmental level	• Financial problems/ poverty • Unemployment • Homelessness/ insecure housing • Negative educational experience • Discrimination • Neighbourhood violence and crime	• Financial security • Employment • Safe and secure accommodation • Positive educational experience • Inclusive community • Safe neighbourhood environment

[6] Living is for everyone (LIFE). Research and Evidence in Suicide Prevention. Available from: http://www.livingisforeveryone.com.au/Research-and-evidence-in-suicide-prevention.html

Risk and *Protective factors* can occur at different levels:

- Individual
- Social and community networks
- Socio-economic, cultural and environmental level conditions

Figure 2: Different levels of risk and protective factors for suicide



Risk and protective factors may be modifiable - things we can change; and non-modifiable - things we cannot change. For example, consider preventing suicides in isolated older men. We can be aware that their age and gender make them at higher risk of suicide but these are non-modifiable factors, however we can deliver interventions to reduce their social isolation and in turn reduce their suicide risk (social isolation is a modifiable factor).

Influencing risk and protective factors

People who attempt to take their own life usually have many risk factors and few protective factors. But risk and protective factors don't explain everything about suicide. Most people with multiple risk factors do not attempt to take their own life, and some who do take their lives have few risk factors and many protective factors.

The challenge in planning action to prevent suicide is to understand, and where possible modify, the many factors that influence whether people are likely to be vulnerable to suicide or, conversely, resilient to adverse life events. Both risk and protective factors need to be taken into account.

The suicide prevention initiatives outlined within this strategy focus on increasing protective factors and reducing risk factors for suicide within Halton.

Preventing suicides

Suicide is not inevitable and can be prevented. Suicide can be prevented through the implementation of evidence-based interventions. The WHO recommends a public health approach to suicide prevention, which incorporates universal, selective and indicated interventions[7], outlined in Table X. Suicide rates are unlikely to decline as long as we confine our prevention efforts only to those who are at immediate risk of attempting suicide. This strategy provides a comprehensive suicide prevention programme which employs a combination of these three approaches.

Table 2: Suicide prevention interventions

Level	Definition	Examples of actions
Universal interventions	Target the general population and cover the population as a whole (irrespective of the degree of risk).	• Promoting population levels of mental health and wellbeing • Restricting access to the means of suicide. • Assisting and encouraging the media to follow responsible reporting practices of suicide
Selective interventions	Focus on sub-populations that are known to be at higher risk of suicide	• Suicide awareness training for staff who come into contact with known high risk groups
Indicated interventions	Aimed at those who are identified as being vulnerable to suicide or who have attempted suicide.	• Provision of support in time of crisis • Ensuring good risk management and continuity of care.

[7] World Health Organization (2012. Public health action for the prevention of suicide: a framework. Available from: http://www.who.int/mental_health/publications/prevention_suicide_2012/en/

Suicide in Halton

Suicide is often the very end point of a complex history of risk factors and events. To prevent suicides in Halton we need to intervene as early as we can prior to this point. In order to inform the suicide prevention initiatives we have included local information on risk and protective factors as well as data on suicide attempts (where available). This important information will guide local suicide prevention initiatives.

The challenges of suicide statistics

The Under-reporting of suicides

It is commonly acknowledged by professionals in the field of suicide research that official statistics underestimate the 'true' number and rate of suicide. There may be stigma attached to reporting a death as suicide which may lead to under-reporting. In the UK, part of the solution to under-reporting has been to include 'deaths of undetermined intent' within the official statistical category of suicide. This attempts to correct for known under-reporting and is thought to produce a more accurate total (and rate) of suicide in a given year. This approach has been followed within this strategy.

The low numbers of suicides

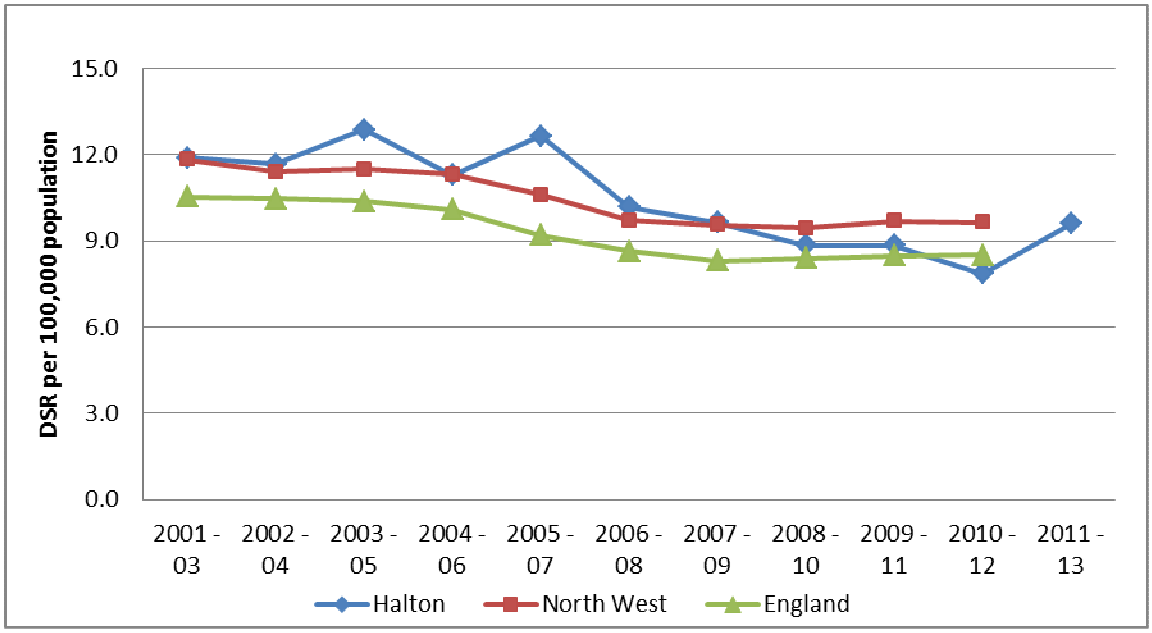
Fortunately the number of people in Halton each year who choose to kill themselves is low. Due to the low numbers of suicides it is important to:

- Use suicide rates per 100,000 people. Using numbers can give a misleading picture when considered alone.
- Not consider increases or decreases for a year at a time in isolation. Three-year rolling averages are generally used for monitoring purposes, in preference to single-year rates, in order to avoid drawing undue attention to year-on-year fluctuations instead of the underlying trend.
- Due to concerns related to the identification of local individuals numbers less than 5 are not presented within this strategy.

Suicide trends in Halton

During the last 5 years in Halton there has been on average 12 suicides per year. As stated due to low numbers it is important not to view a single year's data in isolation. Figure 3 displays three year trends in suicides and undetermined injury in Halton compared to North West and England rates. We can see that since 2005-07 suicide rates in Halton have reduced and in 2010-12 were below both the national and North West rates. Provisional data for 2011-13 suggests an increase in the suicide rate for Halton. We do not yet know how this will compare to national and regional figures which will not be available until early 2015.

Figure 3: Trend in suicides and undetermined injury (All persons, 3 year rolling average) *(Please note 2011-13 data is provisional and not available at a regional or national level).*



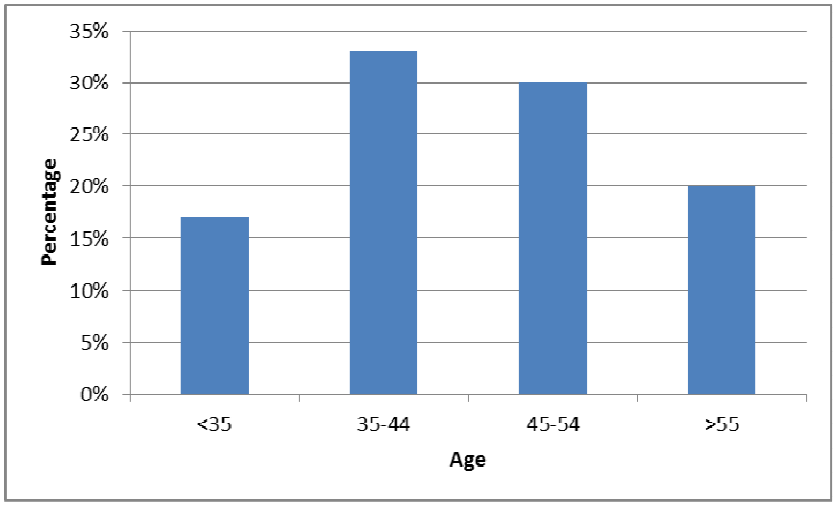
Who dies by suicide in Halton?

Each year an annual suicide audit is undertaken within Halton. Completing the suicide audit improves our understanding of those most at risk of suicide and allows us to target suicide prevention strategies appropriately.

Key findings related to the suicide audit for the period 2011-13

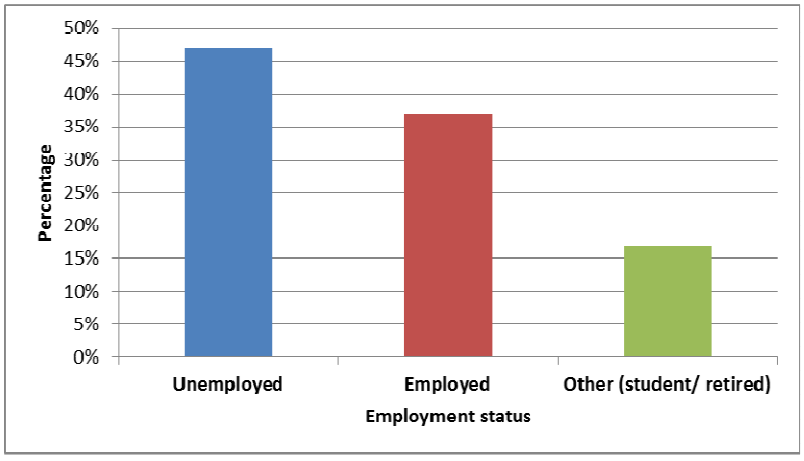
- More men die by suicide in Halton than women. For the period 2011-13 80% of suicide deaths were among men.
- The number and rates of suicides vary between age groups. In Halton the highest numbers of suicides were observed in the 35-44 and 45-54 year old age group (see figure 4).
- The numbers of suicides among those aged under 18 were below 5 therefore the numbers have been supressed.

Figure 4: Age distribution of suicides 2011-13



- The most common marital status at time of death was single (46.7% in 2011-13)
- At the time of death most people were living alone (44% in 2011-13).
- The most common employment status among those who died by suicide was unemployed (47% of deaths for the period 2011-13). This association is stronger for men, 71% of those who died by suicide and were unemployed were male in 2011-13. See figure 5.

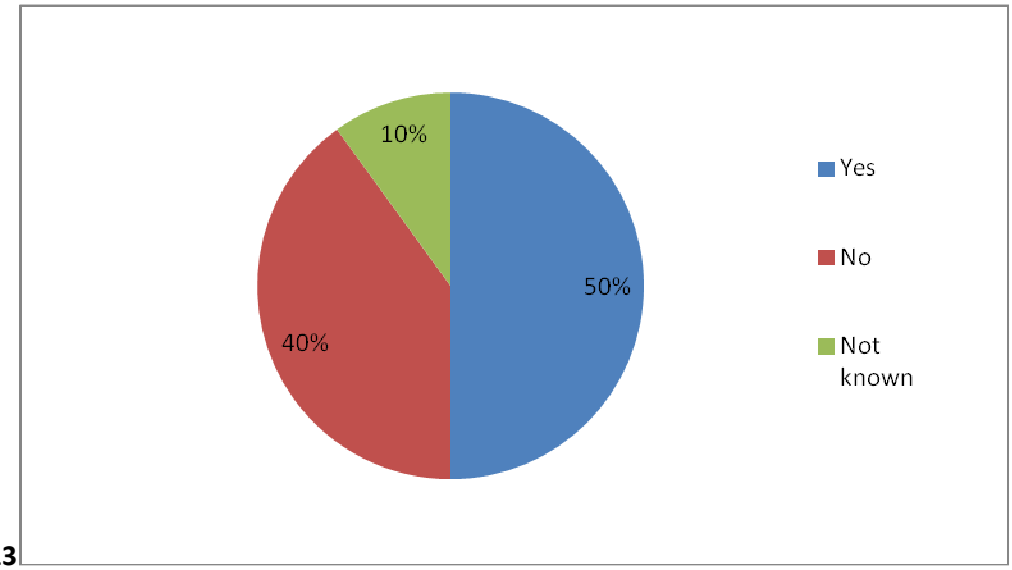
Figure 5: Employment status at time of death 2011-13



- Most of the suicides for the period 2011-2013 were among by heterosexuals (90%), with no one recorded as being homosexual. For 10% of people their sexual orientation was recorded as being unknown.
- The majority of suicides in period 2011-2013 (67%) were reported to have personal problems leading up to their death. The most commonly reported problems were relationship (40%) and financial problems (17%).
- For the period 2011-13 57% of suicides in Halton were by people who had a known mental health problem. Of these 23% were known to mental health services.
- 27% of people who died by suicide in Halton for the period 2011-13 had a recorded history of self-harm.

- Half of those who died by suicide in 2011-13 were misusing substances (alcohol, illicit drugs), 87% of these suicides were in males. See Figure 6.

Figure 6: Substance misuse around the time of death 2011-13



- In the last 3 years, 53% of those who died by suicide had some contact with medical professionals in the last 12 month relating to mental health problems.
- 17% of those who had died by suicide in 2011-13 had contact with the police prior to their death, all were male.

How and where do people die by suicide in Halton?

- Hanging was the most common cause of death by suicide in Halton during the period of 2011-13 accounting for 63% of cases. Hanging was the most common method among both men and women.
- The majority of suicides for the period 2011-13 (60%) died at home. There were small numbers at other locations (less than 5 deaths) including the Silver Jubilee Bridge.

Suicide attempts in Halton

Statistics on recorded suicides (official suicides and undetermined deaths) provide a profile of people who have taken their own life, but do not tell the whole story as they do not provide details of the number of people who have attempted suicide but did not die or the number who have experienced suicidal thoughts.

We do not have data locally on the number of suicide attempts or number of people having suicidal thoughts. However, national surveys inform us that 16.7% of people said that they had thought about committing suicide at some point in their life, while 5.6% said that they had attempted suicide[8]. If these national estimates are applied to Halton's population, we find that nearly 17,000

[8]Adult Psychiatric Morbidity in England - 2007, Results of a household survey. Available from: http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

people local will have ever had suicidal thoughts and over 5,000 people will attempt suicide ever in their lifetime, see Table 3.

Table 3: Estimated prevalence of suicidal thoughts and suicide attempts in Halton

	Percentage (%)	Number
Suicidal thoughts (ever)	16.7	16,836
Suicide attempts (ever)	5.6	5,646

Suicide attempts from the Silver Jubilee Bridge

Locally we have a known suicide hot spot in the Silver Jubilee Bridge (the Runcorn and Widnes Bridge). In the last three years there have been 70 incidents involving the bridge, of these 63 were threats to jump and 7 were people who jumped from the bridge, see Table 4.

During the financial year 2013/14 police resources recorded 494 hours (or over 20 days) of time expended to deal with individuals threatening to jump from the Silver Jubilee Bridge.

Table 4: Incidents in relation to persons who have jumped or attempted to jump from the Silver Jubilee Bridge (the Runcorn and Widnes Bridge), 2011-14

	Total
Threats to Jump from bridge	63
Jumpers from the bridge	7
Total	**70**

Local information related to risk factors for suicide

As stated this suicide prevention strategy focuses on increasing protective factors and reducing risk factors for suicide within Halton. In order for us to prioritise actions it is important for us to be aware of the prevalence of risk factors locally:

- Significantly worse than England:
  - Self-harm rates
  - Long-term health problems and disability
  - Substance misuse
  - Personal insolvency
  - Violent crime and violent offences
- Higher than England
  - First time entrants into youth justice system
  - Levels of alcohol-related harm
  - Unemployment (including youth unemployment)
- Lower than England
  - Ethnic minority groups
  - One person households

Areas for action

This strategy articulates the partnership approach to suicide prevention and supporting those bereaved or affected by suicide in Halton. Based upon national policy, research evidence and local insight 6 areas for action have been identified and agreed. All 6 areas for action have equal priority.

1. **Improve the mental health and wellbeing of Halton residents**
2. **Promote the early identification and support of people feeling suicidal**
3. **Reduce the risk of suicide in known high risk groups**
4. **Reduce access to the means of suicide**
5. **Provide better information and support to those bereaved or affected by suicide**
6. **Support research, data collection and monitoring**

Area for action 1: Improve the mental health and wellbeing of Halton residents

A key aim of this strategy is to promote protective factors and reduce the likelihood of suicidal behaviour through improving a person's mental health and wellbeing and their ability to cope with difficult circumstances.

We know:

- Interventions that promote mental health and wellbeing also reduce suicides

This strategy is aligned with Halton's Mental Health and Wellbeing Commissioning Strategy and Delivery Plan. As such this aim will be delivered via Halton's Mental Health and Wellbeing Commissioning Strategy priority area 1 - "Improve the mental health and wellbeing of Halton people through prevention and early detection" which outlines actions to improve mental health and wellbeing across the life course.

In order to improve the mental health and wellbeing of Halton residents we will:

- Support the delivery of Halton's Mental Health and Wellbeing Commissioning Strategy priority area 1 - "Improve the mental health and wellbeing of Halton people through prevention and early detection"

Area for action 2: Promote the early identification and support of people feeling suicidal

Suicide is often the result of a complex range of factors, but it is often just one or two things that can trigger a person to take actions such as making a suicide plan or finding a means to take their own life.

We know:

- Most people who are thinking of taking their own life do not actually want to die but can't see any other way out of their situation.
- The warning signs and tipping points for suicide can be likened to signposts that give early warning of the potential for suicidal behaviour. Knowing the main warning signs for suicide and responding to them quickly and effectively may save someone's life.

In order to ensure the early identification and support of those who feel suicidal we will:

Supporting people at the time of a mental health crisis: Operation Emblem

'Operation Emblem' was set up in December 2013 as an innovative approach to supporting those suffering from a mental health crisis in Halton.

The scheme involves a Community Psychiatric Nurse accompanying a dedicated Cheshire Police Officer on call-outs involving individuals who are exhibiting unusual behaviour linked with mental illness or drug and alcohol dependency.

The Community Psychiatric Nurse is able to immediately access the individual's care plan, if they are known to services, and to contact their Care Co-ordinator to discuss what the best approach is, as well as offering immediate support to the individual. The benefits of these relationships were made clear as so far around 90 per cent of the individuals seen through the pilot were already known to mental health professionals – giving the police additional insight into their needs and support requirements.

Owing to the team's guidance and support - only four people had to be dealt with by way of a Section 136 arrest, representing an 82.5 per cent reduction. On all of these occasions, the individual was admitted onto a mental health ward within a few hours.

Operation emblem has produced benefits for local people and the economy – easing pressure on local Police resources while offering vulnerable people a more supportive way of accessing 5 Boroughs Partnership NHS Foundation Trust's services which promote compassion and recovery.

In one incident, a concern for welfare was issued to Cheshire Police via a family member regarding a gentleman with mental health problems. Prior to his disappearance, the gentleman had voiced suicidal ideation and had consumed large amounts of alcohol. The gentleman was located by the team and given choice about how he could access appropriate help. He refused to attend a clinic/hospital environment but – by taking a shared decision-making approach – the team were able to stage a street triage intervention.

During de-brief with attending officers it was confirmed that had Operation Emblem not been available, Section 136 of the Mental Health Act would have been utilised. Instead the gentleman received a mental health review within 10 minutes of request and was able to return home with follow-up in the community – evidence of a significantly improved patient experience.

Area for action 3: Reduce the risk of suicide in known high risk groups

Achieving a reduction in suicide involves reaching more people who may be at risk of taking their own lives. Based upon national evidence and local intelligence the groups identified as being at high risk of suicide in Halton include:

Young and middle aged men

We know:

- More men die by suicide in Halton than women. For the period 2011-13 80% of suicide deaths were among men.
- Most men who die due to suicide in Halton are aged 35-64, however suicide remains a leading cause of death among young men

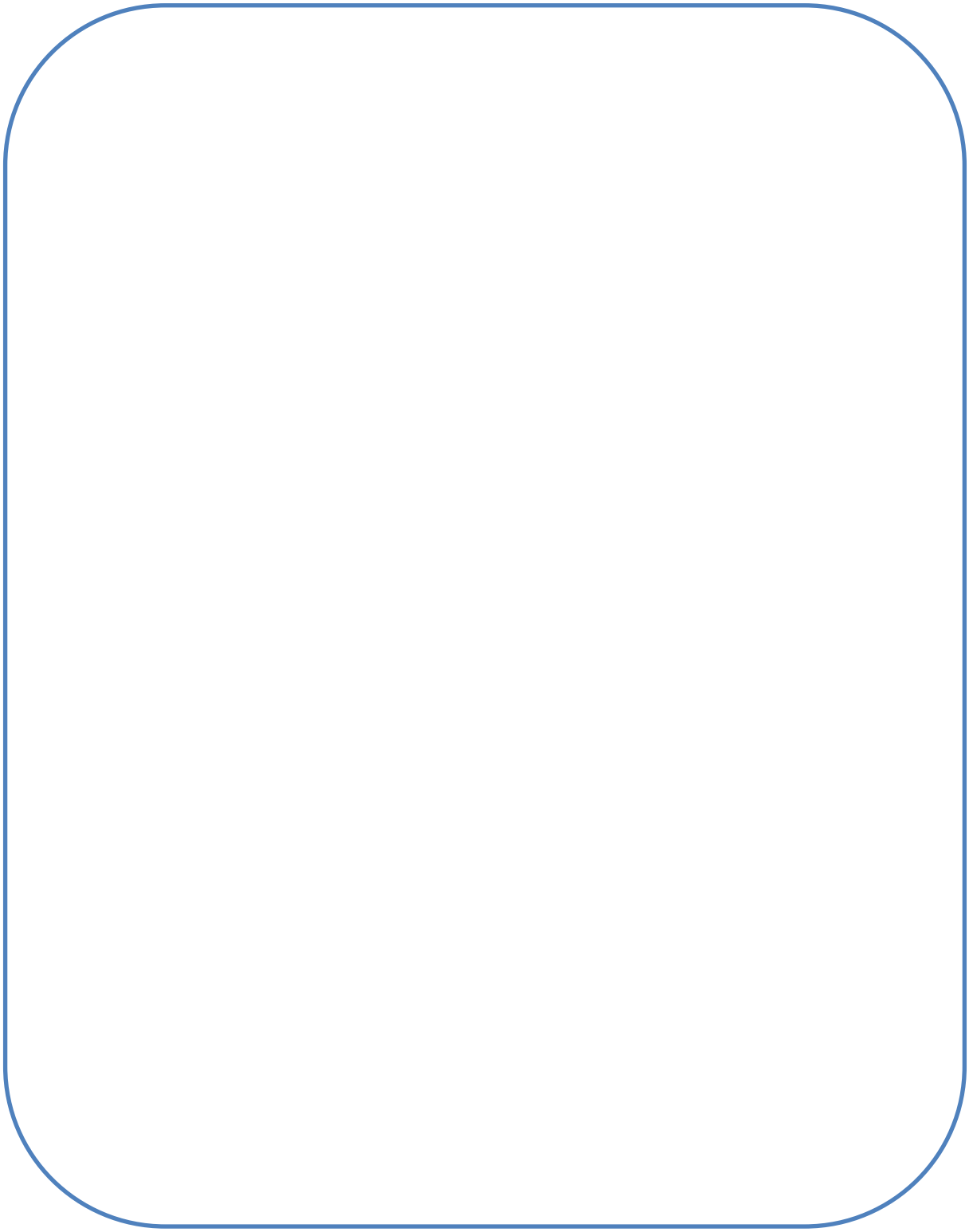
In order to reduce the risk of suicide in young and middle aged men we will:

People with mental health problems, including those in the care of mental health services

We know:

- For the period 2011-13 57% of suicides in Halton were by people who had a known mental health problem. Of these 23% were known to mental health services.
- Depression (including postnatal depression) is one of the most important risk factors for suicide and undiagnosed or untreated depression can heighten that risk.
- Primary care services have a key role in identifying and treating mental health problems as well as assessing an individual's suicide risk.
- People with severe mental illness are at high risk of suicide, both while on inpatient units and in the community.
- Inpatients and those recently discharged from hospital and those who refuse treatment are at highest risk

In order to reduce the risk of suicide in those with a mental health problem we will:



People with a history of self-harm

We know:

- 27% of people who died by suicide in Halton for the period 2011-13 had a recorded history of self-harm.

In order to reduce the risk of suicide in those who self-harm we will:

People in contact with the criminal justice system

We know:

- 17% of those who died by suicide in Halton for the period 2011-13 had been in contact with the police in the period prior to their death

In order to reduce the risk of suicide in those in contact with the criminal justice system we will:

People who misuse drugs or alcohol

We Know:

- 50% of those who died by suicide in Halton for the period 2011-13 were known to have a misusing alcohol or drugs at the time of death.

In order to reduce the risk of suicide in those who misuse drugs or alcohol we will:

Children and young people

We know:

- Young people are vulnerable to suicidal feelings
- Self-harm is common among young people
- Certain young people are at greater risk of suicide e.g. looked after children, children and young people in the criminal justice system, those with mental health and behavioural problems, those who misuse substances, those who have experienced family breakdown, abuse, neglect

In order to reduce the risk of suicide among children and young people in Halton we will:

Older adults

We know:

- Depression, chronic and painful physical illnesses, disability, bereavement, social isolation and loneliness are more common among older people.

In order to reduce the risk of suicide among older adults in Halton we will:

Survivors of abuse and violence including sexual abuse

We know:

- Halton has high levels of domestic abuse and sexual violence
- Violence and abuse can lead to psychosocial problems and an increased suicide risk

In order to reduce the risk of suicide in survivors of abuse and violence including sexual abuse in Halton we will:

Veterans

We know:

- Veterans may suffer from mental health problems due to service.
- There is evidence that risk of suicide is elevated among some veterans

In order to reduce the risk of veterans in Halton we will:

People living with long-term physical health conditions

We know:

- Physical illness is associated with an increased suicide risk.
- People with physical illness are at a higher risk of suffering from depression, which may often go undiagnosed.

In order to reduce the risk of people living with long-term conditions in Halton we will:

People who are especially vulnerable due to social and economic circumstances (for example due to debt, housing problems or unemployment)

We know:

- The UK economy is recovering from the most damaging financial crisis in generations. There have now been a number of studies demonstrating an association between increased unemployment during the recent financial crisis and an increase in suicide rates[9, 10].

[9] Barr B, Taylor-Robinson D, Scott-Samuel A, McKee M, Stuckler D. Suicides associated with the 2008-10 economic recession in England: time trend analysis. BMJ 2012

[10] Chang, Stuckler, Yip, Gunnell. Impact of the 2008 global economic crisis on suicide: time trend study in 54 countries, BMJ 2013,

- Locally the most common employment status among those who died by suicide was unemployed (47% of deaths for the period 2011-13). This association is stronger for men, 71% of those who died by suicide and were unemployed were male in 2011-13.
- There is growing evidence that national policies aimed at reducing austerity e.g. the welfare reforms, the housing benefit size criteria (often referred to as the bedroom tax) may have led to an increase in those experiencing financial difficulties. Recent research conducted with Housing Trust employees found an increase in mental health issues and suicidal ideation among housing trust clients[11].

In order to reduce the risk of suicide in people who are particularly vulnerable due to social and economic circumstances we will:

[11] Impact of Welfare Reform on Housing Employees. Dec 2013

Lesbian, gay, bisexual and transgender people

We know:

- Lesbian, gay, bisexual and transgender people are at a higher risk of mental illness, suicidal ideation, substance misuse and self-harm.

In order to reduce the risk of suicide among lesbian, gay and transgender people in Halton we will:

Area for action 4: Reduce access to the means of suicide

One of the most effective ways to prevent suicide is to reduce access to high lethality means of suicide. This is because people sometimes commit suicide on impulse, and if the means are not readily available the suicidal impulse may pass.

Although most suicides in Halton take place in the home, we also have a known suicide 'hotspot' where repeat suicide attempts take place – the Silver Jubilee Bridge (Runcorn and Widnes Bridge). In addition work has recently commenced on a new Mersey Gateway Bridge with an opening date of autumn 2017 expected for the new crossing.

In order to reduce the number of suicides and suicide attempts at high-risk locations including the Silver Jubilee Bridge (Runcorn and Widnes Bridge) and the new Mersey Gateway Bridge we will:

In order to reduce hanging and strangulation in psychiatric inpatient and criminal justice settings we will:

In order to reduce the number of suicides and suicide attempts on the rail network we will:

Area for action 5: Provide better information and support to those bereaved or affected by suicide

The national Suicide prevention strategy places a new focus on support for people bereaved or affected by suicide.

We know:

- Families and friends bereaved by suicide are at an increased risk of mental health and emotional problems and may be at higher risk of suicide themselves.
- The media has a responsibility to ensure it reports incidents where an individual has taken their own life in a suicide reports in a sensitive manner, so as not to increase distress among relatives and friends of the individual and so as not to promote copycat behaviour among young and vulnerable individuals. can have

In order to provide better information and support to those bereaved or affected by suicide we will:

Developing a postvention service for Halton

Suicide postvention is defined as "the provision of crisis intervention, support and assistance for those affected by a completed suicide".

Evidence suggests that people who know someone who has died by suicide are at greater risk of attempting or completing suicide. For each individual suicide it has been estimated that a further six people will suffer a severe emotional impact as a result of the death.

Postvention services are essential to ensure that those bereaved by suicide receive effective and timely emotional and practical support. There is currently a gap in this area as there is no local care pathway to support those bereaved or affected by suicide.

Evidence from Northern Ireland and Australia demonstrates that such support measurably improves the health and wellbeing of people bereaved or affected by suicide, potentially reducing the number of future suicides. Also that postvention services are cost-effective as through providing effective support they reduce the economic burden on the health system, employers, communities and society generally due to people bereaved or affected by suicide.

A key action identified within this strategy is the development of a postvention service to ensure we have effective local responses to provide effective and timely support for people bereaved or affected by suicide.

Area for action 6: Support research, data collection and monitoring

We know:

- Reliable, timely and accurate suicide statistics and the analysis of the circumstances surrounding each suicide in Halton can highlight trends, identify key risk factors for suicide and inform future partnership activity.
- Research and evaluation enhance our understanding of what works in suicide prevention locally.
- Mechanisms for monitoring progress are essential for the successful delivery of this strategy and action plan.

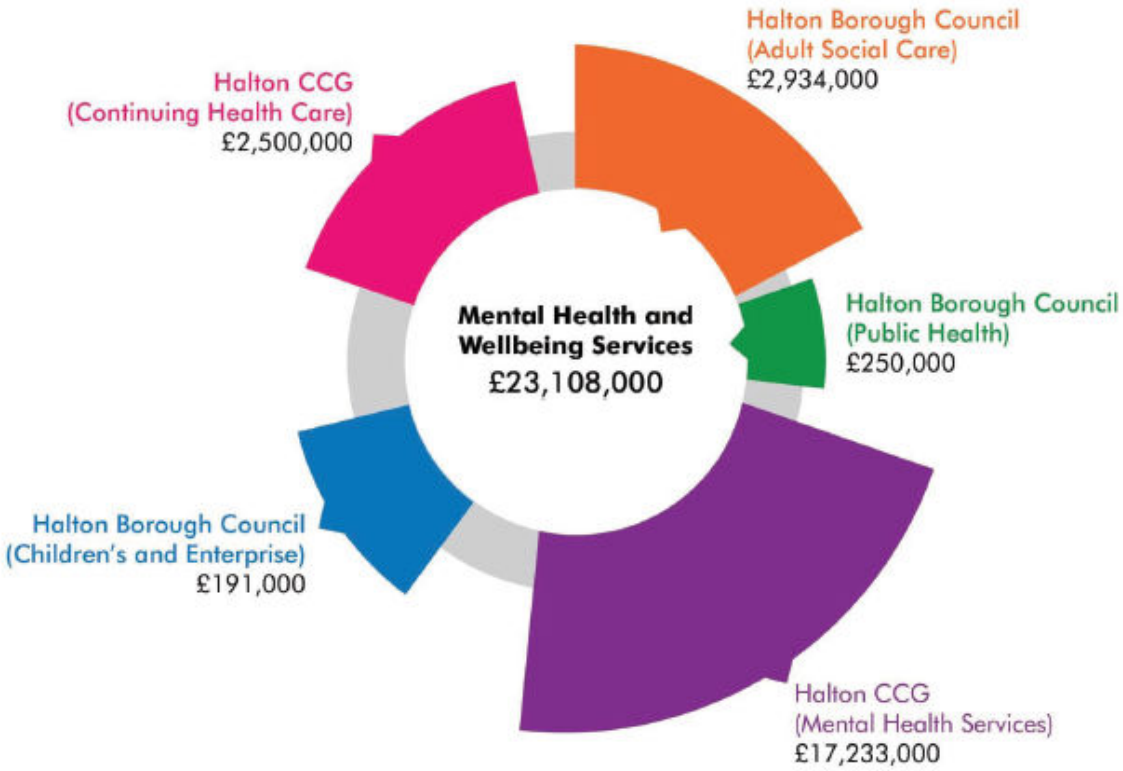
In order to support research, data collection and monitoring we will:

Strategy delivery

Expenditure on suicide prevention

As outlined within this strategy the first step in preventing suicides is to ensure that there are adequate and robust emotional health and wellbeing services available for local people. This includes health promotion and prevention activities as well as safe and effective treatment services with an emphasis on recovery. Halton collectively spends over £23 million on mental health and wellbeing services which can be seen in the diagram below. This spend incudes all local suicide prevention activity e.g. suicide prevention training, CALM funding (Campaign against living miserably), 5BP risk assessment and support services etc.

Figure X: Expenditure on Health and wellbeing services in Halton *Source: A Mental Health and Wellbeing Commissioning Strategy for Halton*



Whilst there is not an explicit budget for local suicide prevention activity it is an integral part of all commissioned activity. Commissioners and service providers have committed to ensure that the actions identified within the strategy and action plan will be prioritised within existing resources with the aim of reducing the risk of suicide locally.

Monitoring implementation and outcomes

This strategy sets out evidence-based actions, based upon national policy, research and local insight, to prevent suicide and support those bereaved or affected by suicide in Halton. The strategy is supported by an action plan which outlines exactly how, by whom and when the agreed actions will be undertaken and the outcomes we hope to achieve.

The ***Halton Suicide Prevention Partnership*** will meet quarterly to monitor the implementation of the action plan and refresh the action plan on an annual basis. Quarterly progress reports will be presented to the Halton Mental Health Oversight Group and the Health and Wellbeing Board.

The *Halton suicide prevention partnership* will monitor outcomes related to high level indicators included within the Public Health and NHS Outcomes Framework this includes:

- the suicide rate
- self-harm rates

- excess under 75 mortality in adults with a serious mental illness

Like Minds
For better mental health in Halton

"My name is David, I'm 30, from Halton View and I've felt **suicidal**.

It started slowly in 2004. I found I was getting more irritable at things and I was drinking alcohol everyday. I started to withdraw from friends and family and was spending more and more time on my own. I then lost my job and split up with my girlfriend. At this point I was at my lowest and wanted to end my life. I felt I had nothing to live for. I talked to my mum about feeling like this and she said I needed to get out more and have a hobby. I knew she was right and I knew I needed to get out and make new friends. It took two years to build the confidence to go to college but I gave it a try and that is where I met my current girlfriend; who I enjoy spending time with and having fun with. I have now begun studying substance misuse and mental health and finally feel up for finding work."

It's Time to Talk.

If you feel like David talk to somebody you trust or see your GP.

For David's full story visit
www.haltonlikeminds.co.uk

Halton suicide prevention strategy – Action plan 2015-16

1. Improve the mental health and wellbeing of Halton people						
Objective	**Targets/ outcomes**		**Actions**	**Timescales**	**Lead**	**Comments**
Improve the mental health and wellbeing of Halton people through prevention and early detection	Increase of 1% in self-reported wellbeing (feeling worthwhile). Baseline (2012) 17.6%	1	Support the delivery of Halton's Mental Health and Wellbeing Commissioning Strategy priority area 1 - "Improve the mental health and wellbeing of Halton people through prevention and early detection"	Ongoing	Mental Health Prevention sub group	
2. Promote the early identification and support of people feeling suicidal						
Objective	**Targets/ outcomes**		**Actions**	**Timescales**	**Lead**	**Comments**
Reduce the stigma and discrimination associated with mental health and suicide locally	Suicide awareness campaign plan developed and agreed by all agencies	2	Develop a local multi-agency suicide awareness campaign plan	Nov 2015	Health improvement team/ Halton suicide prevention partnership	
		3	Ensure suicide prevention support lines are promoted widely across the borough – CALM, Hopeline- UK, Samaritans, Papyrus, and the local assessment team number.	Nov 2015	Halton suicide prevention partnership	

Increase local awareness of the warning signs of suicide and how to access support	1% of the local population is trained in suicide prevention skills. Local organisations have trained their staff in suicide alertness and intervention skills. 3 large local workplaces have been supported in developing suicide prevention policies	4	Deliver suicide awareness training to local community members to enable them to recognise the warning signs of suicide in themselves, their family and friends (LINK TO AREA FOR ACTION 3)	June 2016	Health improvement team	
		5	Develop a local suicide awareness training plan for community members, local community groups and key professionals who interact with known high risk groups (LINK TO AREA FOR ACTION 3)	Jan 2016	Health improvement team/ Public Health	
		6	Support local workplaces to develop suicide prevention policies	June 2016	Health improvement team	
Ensure the prompt support of individuals identified to be at risk	Support services are readily accessible	7	Review local pathways to rapid assessment and support from adult and Child and Adolescent Mental Health Services for those identified to be at risk of suicide	Jan 2016	Halton suicide prevention partnership/ 5BP/ CAMHS partnership board	

	Reduction in the number of Section 136 issued in Halton	8	Support and strengthen Operation Emblem	Jan 2016	Halton CCG/ Cheshire Police/ 5BP	
Improve outcomes for people experiencing a mental health crisis	Crisis care concordat declaration and action plan developed	9	Support the development of a local Crisis concordat declaration and action plan	June 2015	Halton CCG/ 5BP	
Provide extra support to those who re-attempt suicide	Repeat attenders are identified and supported using an MDT approach	10	Take a multidisciplinary approach to supporting individuals who repeatedly attempt suicide	Jan 2016	Halton suicide prevention partnership	
3. Reduce the risk of suicide in known high risk groups						
Reduce the risk of suicide in young and middle aged men	Raised awareness of increased risk of suicide and pathways to support among key front line professionals who work with this group	11	Ensure key front-line professionals and local groups who interact with young and middle aged men undertake suicide awareness training – (LINK TO ACTION 4 + 5)	June 2016	Health improvement team	
		12	Deliver community outreach programmes that promote suicide awareness messages at traditional male settings e.g. in partnership with the Widnes Vikings, at local sports clubs and in local pubs.	June 2016	Health improvement team/ CALM	

Reduce the risk of suicide in people with mental health problems	Raised awareness of increased risk of suicide and pathways to support among key front line professionals who work with this group	13	Deliver suicide awareness training to GPs – explore potential of using BMA e-learning package- (LINK TO ACTION 5)	June 2016	Health improvement team	
		14	Promote the early identification and treatment of depression (LINK TO Halton's Mental Health and Wellbeing Commissioning Strategy)	June 2016	Adult & Older peoples MH Delivery Group	
		15	Ensure the identification and support of women with a possible mental disorder during pregnancy or the postnatal period	June 2016	Midwifery/ Health Visitors	
	Local mental health services benchmarked against best practice	16	Assess local mental health services against best practice using the National Confidential Inquiry into suicide and homicide by people with mental illness self-assessment toolkit - http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/toolkits	Jan 2016	5BP	

		17	Support the implementation of the 5BP Suicide Reduction Strategy	Jan 2016	5BP/ Halton suicide prevention partnership	
Reduce the risk of suicide in People with a history of self-harm	Raised awareness of increased risk of suicide and pathways to support among key front line professionals who work with this group	18	Train key professionals to identify self-harm behaviour, recognise that people who self-harm are a high risk group for suicide and refer appropriately	June 2016	Health Improvement Team	
		19	Support the implementation of NICE clinical practice guidelines on self-harm	June 2016	Halton CCG/ Public Health	
		20	Support the development of a local peer support group for those who self-harm		Health Improvement Team	
Reduce the risk of suicide in People in contact with the criminal justice system	Raised awareness of increased risk of suicide and pathways to support among key front line professionals who	21	Deliver suicide awareness training to key professionals who interact with those in contact with the criminal justice system (LINK TO ACTION 5)	June 2016	Health improvement team	

	work with this group					
Reduce the risk of suicide in who misuse drugs or alcohol	Raised awareness of increased risk of suicide and pathways to support among key front line professionals who work with this group	22	Deliver suicide awareness training to key professionals who interact with those who misuse drugs or alcohol (LINK TO ACTION 5)	June 2016	Health improvement team	
Reduce the risk of suicide in children and young people	Raised awareness of increased risk of suicide and pathways to support among key front line professionals who work with this group	23	Deliver suicide awareness training to key professionals and support groups who interact with children and young people (especially vulnerable children and young people) –(LINK TO ACTION 4 + 5)	June 2016	Health improvement team	
		24	Develop school and college-based approaches to promote suicide awareness among staff, pupils and parents to recognise the warning signs of suicide and increase knowledge of referral routes into specialist support	June 2016	Health Improvement Team/ School nurses	
	All local school and colleges have bullying prevention initiatives	25	Implement school and college-based bullying prevention initiatives (to include tackling cyber bullying and	Jan 2016	Health Improvement Team	

			reducing homophobic bullying)			
	New Tier 2 CAMHS service commissioned	26	Deliver community outreach programmes that promote suicide awareness messages among young people	Jan 2016	HBC Children's commissioner	
		27	Ensure the early support of children and young people with emotional, behavioural or mental health difficulties through a new tier 2 CAMHS service and a specific service for looked after children (LAC)	Jan 2016	CAMHS partnership board	
Reduce the risk of suicide among older adults	Raised awareness of increased risk of suicide and pathways to support among staff and voluntary groups working with older people	28	Deliver suicide awareness training to key professionals and voluntary groups who support older people (LINK TO ACTION 4 + 5)	June 2016	Health Improvement Team	
		29	Promote the early identification and treatment of depression among older adults (LINK TO ACTION)	June 2016	Adult & Older peoples MH Delivery Group	
		30	Support the implementation of the Halton loneliness strategy	Jan 2016	Loneliness strategy group	

Reduce the risk of suicide in Survivors of abuse and violence including sexual abuse	Raised awareness of increased risk of suicide and pathways to support among key front line professionals who work with this group	31	Deliver suicide awareness training to key professionals and local support groups who interact with survivors of abuse and violence (LINK TO ACTION 4 + 5)	June 2016	Health improvement team	
		32	Improve identification and appropriate referral to support services of those experiencing domestic violence – link to domestic abuse strategy	June 2016	Domestic abuse strategy implementation group	
		33	Ensure the early identification and assessment of vulnerable children	Ongoing	Halton safeguarding children's Board	
Reduce the risk of suicide in veterans	Raised awareness of increased risk of suicide and pathways to support among key front line professionals who work with this group	34	Deliver suicide awareness training to key professionals and local support groups who interact with veterans (LINK TO ACTION 4 +5)	June 2016	Health improvement team	
Reduce the risk of suicide in People living with long-term physical health	Long-term conditions programme piloted	35	Support the development of a local long-term conditions patient programme to ensure patients feel	Jan 2016	Public Health	

conditions			more confident in managing their condition and take an active part in their care			
Reduce the risk of suicide in People who are especially vulnerable due to social and economic circumstances (for example due to debt, housing problems or unemployment)	Raised awareness of increased risk of suicide and pathways to support among key front line professionals who work with this group	36	Deliver suicide awareness training to key professionals who interact with People who are especially vulnerable due to social and economic circumstances (LINK TO ACTION 5)	June 2016	Health improvement team	
		37	Develop referral pathways between services that support people who may be vulnerable due to social/ economic circumstances (financial advice and debt support services, housing trusts, employment support agencies) and mental health services	Jan 2016	Halton Suicide Prevention partnership	
Reduce the risk of suicide in lesbian, gay, bisexual and transgender people	Raised awareness of increased risk of suicide and pathways to support among key front line professionals who	38	Deliver suicide awareness training to key professionals and local support groups who interact with lesbian, gay, bisexual and transgender people – (LINK TO ACTION 4 + 5)	June 2016	Health Improvement Team	

	work with this group	39	Implement school and college-based bullying prevention initiatives to reduce homophobic bullying – (LINK TO ACTION 21)	Jan 2016	Halton anti-bullying partnership group	
Area for action 4: Reduce access to the means of suicide						
Reduce the number of suicides and suicide attempts at high-risk locations including the Silver Jubilee Bridge (Runcorn and Widnes Bridge) and the new Mersey Gateway Bridge	Best practice evidence reviewed	40	Review best practice evidence related to reducing the risk of suicide at the Silver Jubilee Bridge (installation of physical barriers, placement of signs and telephones, camera)	June 2016	HBC Emergency Planning team/ Cheshire Police	
		41	Advise on suicide prevention interventions planned for the new Mersey Gateway Bridge	June 2016	HBC Emergency Planning team/ Cheshire Police	
		42	Work with local authority planning departments and developers to consider safety when designing new buildings/ structures to reduce suicide opportunities	Ongoing	Cheshire Police (architectural liaison officer)	
Reduce hanging and strangulation in psychiatric inpatient and criminal justice settings	Evidence of regular ward assessments	43	Ensure regular assessment of ward areas to identify and remove potential risks e.g. ligature ligatures and ligature points, access to medications, access to windows and high risk areas – LINK TO ACTION 12)	Ongoing	5BP	

		44	Ensure safer environment for at risk prisoners e.g. safer cells and provide care for at-risk prisoners	Ongoing	Cheshire Police	
Reduce the number of suicides and suicide attempts on the rail network		45	Ensure staff working on the rail network are trained to recognise the warning signs of suicide and help individuals access appropriate support	June 2016	Regional suicide prevention network	
Area for action 5: Provide better information and support to those bereaved or affected by suicide						
Provide better information and support to those bereaved or affected by suicide	Postvention service commissioned	46	Commission a postvention service to ensure we have effective local responses to the aftermath of a suicide	June 2016	Public Health	
	Peer support group successfully running in Halton	47	Support a local peer support group for those bereaved or affected by suicide	June 2016	Health Improvement Team	
	Updated media reporting guidelines produced and distributed to local	48	Promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media – updated guidelines for media produced	June 2016	Health Improvement Team / Regional suicide prevention network	

	media outlets					
Area for action 6: Support research, data collection and monitoring						
Monitor local suicide trends	Annual audit conducted and shared with key partners	49	Produce an annual data report to ensure that local data relevant to suicide prevention activity is collected, shared between partners and used to monitor suicide trends, progress and inform local activity.	June 2015	Public Health	
		50	Continue to undertake an annual local suicide audit based upon coroners records	June 2015	Public Health	
Evaluate local suicide prevention activities	Evaluation of local suicide prevention activities undertaken to inform future practice	51	Develop mechanisms to evaluate local suicide prevention activities and training in order to inform future practice	June 2016	Public Health	
Review regional and local evidence of best practice	Halton plays an active role in the regional Cheshire and Merseyside Suicide	52	Maintain an active role in the regional Cheshire and Merseyside Suicide Reduction Network	Ongoing	Public Health/ Halton suicide prevention partnership	

	Reduction Network	53	Assess the suitability of effective regional and national suicide prevention interventions for local implementation	Ongoing	Public Health/ Halton suicide prevention partnership	

REPORT TO: Health and Wellbeing Board

DATE: 14th January 2015

REPORTING OFFICER: Simon Banks, Chief Officer

PORTFOLIO: Health and Wellbeing

SUBJECT: Developing a NHS Halton CCG response to *Next steps towards primary care co-commissioning*

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 On 10th November 2014 NHS England, in partnership with NHS Clinical Commissioners, published *Next steps towards primary care co-commissioning*. The document aims to provide clarity and transparency around co-commissioning options, providing CCGs and area teams with the information and tools they need to choose and implement the right form of co-commissioning for their local health economy. NHS Halton CCG needed to decide by 9th January 2015, the level of primary care co-commissioning the organisation wishes to undertake with NHS England.

2.0 RECOMMENDATION: The Health and Wellbeing Board are invited to review this paper and receive a verbal update from NHS Halton CCG.

3.0 SUPPORTING INFORMATION

3.1 In May 2014, NHS England invited CCGs to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities. There has been a strong response from CCGs wishing to assume co-commissioning responsibilities. NHS Halton CCG submitted an expression of interest in co-commissioning of primary care services in June 2014.

3.2 NHS England now wants to harness this energy and address the frustrations CCGs have expressed in the current primary care commissioning arrangements, to more effectively shape high quality local services. The purpose of *Next steps towards primary care co-commissioning* is to give CCGs an opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each model, including associated

functions; governance arrangements; resources; and any potential risks, with advice on how to mitigate these. The document then sets out the steps towards implementing co-commissioning arrangements, including the timeline and approvals process.

3.3 Co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. The *Five Year Forward View* emphasises the need to increase the provision of out-of-hospital care and to break down barriers in how care is delivered. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will drive the development of new integrated out-of hospital models of care, such as multispecialty community providers and primary and acute care systems.

3.4 Co-commissioning will give CCGs the option of having more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services. By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained. Co-commissioning could potentially lead to a range of benefits for the public and patients, including:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities; and
- A better patient experience through more joined up services.

3.5 Co-commissioning could also lead to greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services. Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and information management and technology challenges.

3.6 Primary care co-commissioning is the beginning of a longer journey towards place based commissioning – where different commissioners come together to jointly agree commissioning strategies and plans, using pooled funds, for services for a local population. From 1 April 2015 NHS England will be extending personal commissioning through The Integrated Personal Commissioning (IPC) programme. The IPC programme aims to bring health and social care together, identifying the totality of expenditure at the level of the individual, giving people more control over how this is used and enabling money to be spent in a more tailored way. Furthermore, from 2015/16 CCGs will have the

opportunity to co-commission some specialised services through a joint committee. NHS England has also been encouraging CCGs and local authorities to strengthen their partnership approach so they can jointly and effectively work to align commissioning intentions for NHS, social care and public health services.

3.7 *Next steps towards primary care co-commissioning* gives clinical commissioning groups (CCGs) the opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each co-commissioning model and the steps towards implementing arrangements. The document has been developed by the joint CCG and NHS England Primary Care Commissioning Programme Oversight Group in partnership with NHS Clinical Commissioners.

3.8 Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

3.9 There are three primary care co-commissioning models CCGs could take forward:

- Greater involvement in primary care decision making.
- Joint commissioning arrangements.
- Delegated commissioning arrangements.

3.10 The scope of primary care co-commissioning in 2015/16 is general practice services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. However, co-commissioning excludes all functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation). Furthermore, the terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

3.11 Under joint and delegated arrangements, CCGs will have the opportunity to design a local incentive scheme as an alternative to the Quality and Outcomes Framework (QOF) or Directed Enhanced Services (DES). This is without prejudice to the right of GMS practices to their entitlements, which are negotiated and set nationally. In order to ensure national consistency and delivery of the democratically-set goals for the NHS outlined in the Mandate set for us by the government, NHS England will continue to set national standing rules, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF and IT

intra-operability.

3.12 In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances. CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest. In delegated arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act.

3.13 With regards to governance arrangements, draft governance frameworks and terms of reference for joint and delegated arrangements on behalf of CCGs have been developed. CCGs are encouraged to utilise these resources when establishing their governance arrangements.

3.14 A significant challenge of primary care co-commissioning is finding a way to ensure that CCGs can access the necessary resources as they take on new responsibilities. Pragmatic and flexible local arrangements for 2015/16 will need to be agreed by CCGs and area teams.

3.15 Conflicts of interest need to be carefully managed within co-commissioning. Whilst there is already conflicts of interest guidance in place for CCGs, this will be strengthened in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. A national framework for conflicts of interest in primary care co-commissioning will be published as statutory guidance in December 2014.

3.16 The approvals process for co-commissioning arrangements will be straightforward. The aim is to support as many CCGs as possible to implement co-commissioning arrangements by 1 April 2015. Unless a CCG has serious governance issues or is in a state akin to “special measures”, NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs who wish to implement joint or delegated arrangements will be required to complete a short proforma and request a constitution amendment. The approvals process will be led by regional moderation panels with the new NHS England commissioning committee providing final sign off for delegated arrangements. The timescales for submissions are:

- Joint commissioning – 30th January 2015
- Delegated commissioning, noon, 9th January 2015

4.0 **POLICY IMPLICATIONS**

4.1 NHS Halton CCG has been required, within short timescales, to consider the three models of co-commissioning that have been presented to the organisation. It is arguable that the first of these approaches, greater involvement in primary care co-commissioning, simply reflects where the organisation was at its inception – collaborating closely with our area team to ensure that decisions taken about healthcare services are strategically aligned across the local health economy and assisting NHS Halton CCG in fulfilling the duty to improve the quality of primary medical care. NHS Halton CCG therefore had a choice of two approaches, joint commissioning or delegated commissioning.

4.2 Joint Commissioning

4.2.1 A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common". Joint commissioning arrangements give CCGs and area teams an opportunity to more effectively plan and improve the provision of out-of hospital services for the benefit of patients and local populations. Within this model CCGs also have the option to pool funding for investment in primary care services.

4.2.2 In 2015/16, joint commissioning arrangements will be limited to general practice services. The functions joint committees could cover are:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

4.2.3 Joint commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS CCGs could either form a joint committee or "committees in common" with their area team in order to jointly commission primary medical services. With regards to joint committees, due to the passing of a Legislative Reform Order (LRO) by parliament, CCGs can now form a joint committee with one or

more CCGs and NHS England. NHS England's scheme of delegation is being reviewed and will be revised as appropriate to enable the formation of joint committees between NHS England and CCGs i.e., where NHS England invites one or more CCGs to form a joint committee.

4.2.4 A model terms of reference for joint commissioning arrangements, including scheme of delegation has been developed by NHS England. This model applies to the establishment of a joint committee between the CCG (or CCGs) and NHS England. If CCGs and area teams intend to form a joint committee, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures. The joint committee structure allows a more efficient and effective way of working together than a committees-in-common approach and so this is the recommended governance structure for joint commissioning arrangements.

4.2.5 In joint commissioning arrangements, individual CCGs and NHS England always remain accountable for meeting their own statutory duties, for instance in relation to quality, financial resources, equality, health inequalities and public participation. This means that in this arrangement, NHS England retains accountability for the discharge of its statutory duties in relation to primary care commissioning. CCGs and NHS England must ensure that any governance arrangement they put in place does not compromise their respective ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making. Arrangements should also comply with the conflicts of interest guidance.

4.2.6 The effectiveness of joint arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. NHS England and CCGs need to ensure that any governance arrangements put in place enable them to collaborate effectively.

4.2.7 It is for area teams and CCGs to agree the full membership of their joint committees. In the interests of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the joint committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

4.2.8 CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of

stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. It will be important to retain clinical leadership of commissioning in a joint committee arrangement to ensure the unique benefits of clinical commissioning are retained.

4.2.9 CCGs and area teams may wish to consider implementing a pooled fund arrangement under joint commissioning arrangements as per section 13V of Chapter A1 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). Establishing a pooled fund will require close working between CCG and area team finance colleagues to ensure that the arrangement establishes clear financial controls and risk management systems and has clear accountability arrangements in place.

4.2.10 The funding of core primary medical services is an NHS England statutory function. Although NHS England can create a pooled fund which a CCG can contribute to, the CCG's contribution must relate to its own functions and so could not relate to core primary medical services. However, CCGs are able to invest in a way that is calculated to facilitate or is conducive or incidental to the provision of primary medical care and provided that no other body has a statutory duty to provide that funding.

4.3 Delegated Commissioning

4.3.1 Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning. Therefore, NHS England will require robust assurance that its statutory functions are being discharged effectively. Naturally, CCGs continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation.

4.3.2 NHS England and NHS Clinical Commissioners have agreed that a standardised model of delegation would make most sense for practical reasons. CCGs have expressed a strong interest in assuming the following primary care functions which will be included in delegated arrangements:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services

(DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

4.3.3 Delegated commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England will also be responsible for the administration of payments and list management. CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no decision making role.

4.3.4 NHS England has developed a model governance framework for delegated commissioning arrangements in order to avoid the need for CCGs to develop their own model. The recommendation is that CCGs establish a primary care commissioning committee to oversee the exercise of the delegated functions. A model terms of reference for delegated commissioning arrangements including scheme of delegation has been developed. If CCGs intend to assume delegated responsibilities, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures.

4.3.5 A formal document which records the delegation of authority by NHS England to CCGs will be issued once the approvals process is completed. In delegated commissioning arrangements, CCGs will remain accountable for meeting their own pre-existing statutory functions, for instance in relation to quality, financial resources and public participation. CCGs must ensure that any governance arrangement they put in place does not compromise their ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making.

4.3.6 It is for CCGs to agree the full membership of their primary care commissioning committee. CCGs will be required to ensure that it is chaired by a lay member and have a lay and executive majority. Furthermore, in the interest of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the delegated committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

4.3.7 CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. Furthermore, it will be important to retain clinical involvement in a delegated committee arrangement to ensure the unique benefits of clinical commissioning are retained.

4.4 Implications for NHS Halton CCG

4.4.1 Co-commissioning is now firmly established as a direction of travel within the NHS. The guidance recognises that CCGs are at different stages of their developmental journey and are facing a variety of local challenges. Therefore it is likely that the appetite to take on further responsibilities for primary care co-commissioning will vary across the country. It is nonetheless clear that NHS England wants CCGs to enter into joint commissioning arrangements for 2015/16 before taking on delegated responsibilities for 2016/17. At the NHS Halton CCG Governing Body on 4th December 2014 it was recommended an expression of interest should be submitted for the organisation to assume delegated commissioning for 2015/16.

4.4.2 Both models, joint commissioning and delegated commissioning, involve the establishment of the appropriate governance mechanisms to support impartial decision making, engage with the local population and avoid conflicts of interest. The establishment of a set of governance arrangements for joint commissioning would be as time consuming as for delegated commissioning. Furthermore, if joint commissioning were to be pursued, another iteration of changes in governance would need to follow for delegated commissioning. It cannot be guaranteed that NHS England would have sufficient numbers of people to attend a joint committee, which could impair the ability of such an arrangement to function effectively. Joint commissioning would also involve an additional set of governance beyond the Governing Body, whereas delegated commissioning could be more easily established around existing arrangements. In terms of governance arrangements, it is therefore suggested that it would be more appropriate and efficacious to take on delegated commissioning from 2015/16.

4.4.3 A significant challenge involved in implementing primary care co-commissioning is finding a way to ensure that all CCGs can access the necessary resources as they take on new co-commissioning responsibilities. This challenge exists whatever model NHS Halton CCG decides upon.

4.4.4 Primary care commissioning is currently delivered by teams covering

a large geography normally spanning several CCGs, and also covering all parts of primary care not just limited to general practice. There is no possibility of additional administrative resources being deployed on these services at this time due to running cost constraints. It is arguable that NHS Halton CCG is already complementing and potentially supplementing these existing arrangements with our own resources, the development of the strategy for general practice services in the borough being one example. In short, NHS Halton CCG is already engaged in a *de facto* joint commissioning arrangement and it would not take a significant amount of redesign to deliver delegated commissioning.

4.4.5 Pragmatic and flexible local solutions will need to be agreed by CCGs and area teams to put in place arrangements that will work locally for 2015/16. These local agreements will need to ensure that:

- CCGs that take on delegated commissioning responsibilities have access to a fair share of the area team's primary care commissioning staff resources to deliver their responsibilities; and
- Area teams retain a fair share of existing resources to deliver all their ongoing primary care commissioning responsibilities.

4.4.6 Whether NHS Halton CCG pursues joint or delegated commissioning, a conversation will be needed with the area team regarding accessing support through their existing primary care team. Again, it would be preferable to have such a conversation once. Given the limited size of existing primary care teams, potentially only part-time capacity would be available for individual CCGs taking on delegated commissioning responsibility, so it may be that collaborative arrangements between CCGs would be desirable to achieve greater critical mass. Staffing models for these arrangements will vary across the country and will require careful discussion to ensure that the practical, legal and staff engagement issues are clearly understood. We understand that the majority of CCGs in Cheshire and Merseyside, which will be the geography served by the new Area Team, are exploring delegated commissioning and will be potentially 'fishing in the same pond' for resources. NHS Halton CCG needs to be an active participant in these discussions alongside like-minded CCGs.

4.4.7 NHS England will ensure transparency in sharing financial information on primary care with CCGs. All CCGs will have the opportunity to discuss the current financial position for all local primary care services with their area team. CCGs will be provided with an analysis of their baseline expenditure for 2014/15 broken down between GP services and other primary care services by the end of November 2014. Final decisions regarding allocations for 2015/16 will be made by the NHS England Board in December

2014.

4.4.8 NHS England recognises that it will be challenging for some CCGs to implement co-commissioning arrangements, especially delegated arrangements, without an increase in running costs. Whilst it is not within their gift to increase running costs in 2015/16, NHS England will keep this situation under review. CCGs should discuss with area teams options for sharing administrative resource to support the commissioning of primary care services.

4.4.9 In delegated arrangements, CCGs will receive funding for known future cost pressures within current allocations e.g. net growth in list sizes. In such circumstances, there may be a linked efficiency requirement which will need to be delivered in order for budgets to balance. Furthermore, if supported by clear strategies, CCGs would also have greater flexibility to "top up" their primary care allocation with funds from their main CCG allocation. Delegation would therefore give NHS Halton CCG greater control than joint commissioning in terms of resource allocation, which would enable the delivery of any aspirations for revised care models that emerge from our *Strategy for General Practice Services in Halton* or in response to *Five Year Forward View*.

4.4.10 NHS England is taking steps to move towards a fair distribution of resources for primary care, based on the needs of diverse populations. The GMS Minimum Practice Income Guarantee (MPIG) will be phased out by April 2020, and a review of local PMS agreements is underway as set out in the Framework for Personal Medical Services (PMS) Contracts Review. Area teams should ensure that any decisions relating to future use of PMS funding are agreed with CCGs. We envisage that CCG and primary care allocations will continue to move towards a fair distribution of resources and reflect inequalities, as in the current CCG formula. As part of any delegation of primary care commissioning responsibilities, area teams will provide details of any differential funding levels across localities. Again, it is arguable that a delegated model would give NHS Halton CCG more influence over the future use of PMS funding.

4.5 <u>Decision Making</u>

4.5.1 At the time of writing, NHS Halton CCG is preparing to make a firm decision as to which of the three co-commissioning options the organisation should pursue. It will be recommended to the CCG's Governing Body on 4th December 2014 that a submission for delegated commissioning should be developed, rather than a submission for joint commissioning. This document needs to be completed and submitted by noon on 9th January 2014.

4.5.2 The guidance states that, as membership organisations, CCGs

should fully engage with their members when considering co-commissioning options. It also suggests that it would be of benefit it the CCG and local stakeholders such as patients, local authorities, Health and Wellbeing Boards and HealthWatch had an open and inclusive conversation about options and possible arrangements.

4.5.3 Unfortunately the time frame within which NHS Halton CCG Governing Body needs to make a decision is not conducive to meaningful engagement with member practices or other partners. The paper that went to the NHS Halton CCG Governing Body on 4th December 2014 therefore proposed that a draft submission supporting delegated commissioning is drawn up and comments invited from member practices and other key partners by 19th December 2014. The submission would also be discussed at the NHS Halton CCG Service Development Committee on 10th December 2014 with clinical and practice leads and at the Governing Body Development Session on 18th December 2014. The final submission would be ratified by the Governing Body on 8th January 2015.

4.5.4 The Health and Wellbeing Board will be given a verbal update on the outcomes of this work.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Co-commissioning will need to be delivered within existing programme and running cost allowance budgets. There may be opportunities for pooled or delegated budgets and other resources depending on the model followed.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None as a result of this report.

6.2 Employment, Learning & Skills in Halton

None as a result of this report.

6.3 A Healthy Halton

None as a result of this report.

6.4 A Safer Halton

None as a result of this report.

6.5 Halton's Urban Renewal

None as a result of this report.

7.0 RISK ANALYSIS

7.1 The greatest risk arising from co-commissioning is the ability of NHS Halton CCG to deliver additional commissioning responsibilities with existing resources.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 NHS Halton CCG will be required to ensure that it is compliant with the duties upon public bodies under the Equality Act 2010 as co-commissioning develops.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Five Year Forward View, Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority, 23rd October 2014, www.england.nhs.uk/ourwork/futurenhs/.

NHS England and NHS Clinical Commissioners, *Next steps towards primary care co-commissioning*, NHS England, Gateway Reference 02501, 10th November 2014, www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf.

REPORT TO:	Health and Wellbeing Board
DATE:	14 January 2015
REPORTING OFFICER:	Simon Banks, Chief Officer
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Maternity Services
WARDS:	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To inform the Health and Wellbeing Board of work that is progressing across Cheshire and Merseyside to sustain and develop maternity services.

2.0 RECOMMENDATION: That the Health and Wellbeing Board note the report.

3.0 SUPPORTING INFORMATION

3.1 Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade and are at their highest in 40 years.

3.2 Whilst the majority of women have low risk pregnancies, have a positive experience of birth and deliver healthy babies, this is not always the case. There has been an increase in the complexity of births and there is variation in the outcomes and experience of women and babies.

3.3 Cheshire and Merseyside Clinical Commissioning Groups (CCGs) have agreed to undertake a review of maternity services across the sub-region. This review is being undertaken with the support of provider organisations and the Cheshire and Merseyside Strategic Clinical Network (SCN). The involvement of the SCN is crucial as this ensures that clinicians are engaged in and leading this work.

3.4 Through this review, the NHS in Cheshire and Merseyside will explore how it can improve outcomes, reduce variation, deliver high quality services and sustain and develop maternity provision across the area. From this work, which will stay close to the national agenda as set out in the NHS *Five Year Forward View*, future options for sustainable maternity services will be explored with the intention that the NHS is able to offer better choice, improved outcomes and a model of care with mothers, babies and families at the heart of it.

3.5 Work is currently underway to develop a baseline understanding of the nature and shape of maternity services in Cheshire and Merseyside. Using all available data this is specifically looking at:

- clinical outcomes
- patient experience and choice
- education and training of the current and future workforce
- co-dependencies with other services including neonatal intensive care, co-surgical support, critical care, A&E and other specialist services
- safeguarding
- capacity and size of current provision
- current and future demographics and geographical access
- epidemiology of the population
- current commissioning and financial arrangements

3.6 The next phase of the work will involve developing options for improvement, using evidence of national and international best practice. Any options for change will be subject to engagement and consultation with patients and the public in Cheshire and Merseyside.

4.0 POLICY IMPLICATIONS

4.1 The work on maternity services in Cheshire and Merseyside needs to be linked to the NHS *Five Year Forward View*. The *Five Year Forward View* states that, in addition to increasing midwife numbers, the NHS will:

- Commission a review of future models for maternity units, to report by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS.
- Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.
- Make it easier for groups of midwives to set up their own NHS-funded midwifery services.

5.0 OTHER IMPLICATIONS

5.1 The review will take into account the funding of NHS maternity services, which are resourced through a nationally agreed tariff.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**
The Children's Trust will need to stay close to this review.

6.2 **Employment, Learning and Skills in Halton**
None as a result of this report.

6.3 **A Healthy Halton**
None as a result of this report.

6.4 **A Safer Halton**
None as a result of this report.

6.5 **Halton's Urban Renewal**

None as a result of this report.

7.0 RISK ANALYSIS

7.1 A lack of engagement in and awareness of the review is a significant risk. This risk will be mitigated as the review progresses with an engagement plan.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The review will be undertaken in a way that ensures that it is compliant with the duties upon public bodies under the Equality Act 2010.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Five Year Forward View, Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority, 23rd October 2014, www.england.nhs.uk/ourwork/futurenhs/.

REPORT TO: Health and Wellbeing Board

DATE: 14 January 2015

REPORTING OFFICER: Director of Public Health.

PORTFOLIO: Health and Wellbeing

SUBJECT: Pharmaceutical Needs Assessment

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide members of the Board with the final version of the Pharmaceutical Needs Assessment (PNA) and briefing on the results of the statutory 60-day consultation.

2.0 RECOMMENDATION: That

1. **the Board approve the PNA for publication; and**

2. **the Board delegate the Steering Group to deal with production of supplementary statements needed throughout the lifetime of the PNA**

3.0 SUPPORTING INFORMATION

3.1 The pharmaceutical needs assessment is a statutory document that states the pharmacy needs of the local population. This includes dispensing services as well as public health and other services that pharmacies may provide. It is used as the framework for making decisions when granting new contracts and approving changes to existing contracts as well as for commissioning pharmacy services. First detailed in the NHS Act 2006 where PCTs were divested with the responsibility for producing the PNA, since 1 April 2013 this responsibility now sits with Health & Wellbeing Boards (HWB).

3.2 Background to the PNA

National guidance states that the PNA should detail the current pharmaceutical service provision available in the area and where there may need to be changes to this in the future because of changes to the health needs or geographical location of the local population. The guidance, in line with regulations, includes both minimum content of a PNA and the process that must be followed.

The PNA is designed to be a statement of fact, both the current position and where there are 'known firm plans' in place to review or amend provision based on need, evidence of effective practice and identified gaps in provision. Also to assess where there are 'known firm plans' for new developments or population changes which may impact on the needs of pharmaceutical services. It is designed to assess the need for pharmaceutical services and adequacy of provision of pharmaceutical services, not to assess general health needs. The latter is the role of the Joint Strategic Needs Assessment (JSNA). Preparation of the PNA has taken account of the needs identified in the JSNA, where they are relevant to pharmaceutical services.

At the 17 September 2014 HWB meeting, the Board authorised the commencement of the statutory 60-day consultation.

3.3 **Statutory 60-day consultation**

The Regulations set out that HWBs must consult the bodies set out in Regulation 8 at least once during the process of developing the PNA.

Regulation 8(1) states that the HWB must consult the following list as a minimum during the development of the PNA:

(a) Local Pharmaceutical Committee(s) for its area;
(b) Local Medical Committee(s) for its area;
(c) all pharmacy contractors and any dispensing doctors for its area;
(d) any LPS chemist in its area with whom the NHS England has made arrangements for the provision of any local pharmaceutical services;
(e) Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB has an interest in the provision of pharmaceutical services in its area;
(f) NHS trusts or NHS foundation trusts in its area;
(g) NHS England
(h) neighbouring HWBs.

3.4 **60-day consultation process**

A standard letter was sent to all organisations detailed in Section 3.3. Additionally the invitation to participate in the consultation was sent out to a wider range of stakeholders via various partnerships.

The consultation opened Monday 24 September 2014 and ended at close of normal business hours on Monday 24 November 2014. A total of 6 responses were received. However, one referred to the previous, 2011, PNA and so was omitted from the responses detailed in Appendix 9 of the PNA.

The consultation formed a set of questions to which respondents could agree or disagree with space in each question to make comments. The survey was available online or could be filled in by downloading the questionnaire in a word document format.

3.5 **60-day consultation results**

Overall the respondents were very positive about the way we had developed the PNA, stating it was clear what we were trying to achieve. The majority agreed with the findings. A number of comments were made:

- There was one comment about whether the statement of overall provision being adequate was strong enough and that it was not clear if we were saying no further NHS pharmaceutical service providers were needed. This statement was subsequently strengthened by the Steering Group within the Key Findings of both the Executive Summary and Main Document
- There were a couple of comments about particular pieces of evidence that could be added to Section 7 which looks at health needs and pharmacy services to address these. The Steering Group looked at each to decide if they should be added
- It was pointed out that the Regulations stipulate that the PNA detail what approach to localities has been used. The PNA uses the broad categories of Widnes and Runcorn, with health data at ward level. Mapping of need and service provision enables an overall assessment to adequacy to be made. A short section has been added to the PNA stating the approach (section 2.6)
- A query about whether Halton people can access all services provided by out-of-borough pharmacies was raised and this has been responded to
- Opening times of two pharmacies were checked and amendments made to the table that constitutes Appendix 3 for one of them. For the other the information was already correct within the draft PNA
- Comments about possible service developments have been passed on to the relevant commissioners

The Steering Group met on 3 December 2014 and prepared responses to each comment. These are included in the PNA, Appendix 9. All necessary amendments have been made to the final version of the PNA.

3.6 **Proposed next steps**

- The PNA must be published no later than 1 April 2015

- The Health & Wellbeing Board are asked to approve this draft of the PNA
- The PNA is uploaded onto Halton Borough Council's website as part of the Public Health pages detailing the JSNA
- This is communicated to key stakeholders and the public
- The Steering Group will meet periodically and as needed to produce supplementary statements during the lifetime of the PNA. These are needed if and when there are minor amends which do not substantially alter provision of pharmaceutical services. An example of this would be if a pharmacy changed their opening hours

4.0 POLICY IMPLICATIONS

4.1 The health needs identified in the JSNA have been used to develop the PNA.

The PNA provides a robust and detailed assessment of the need for pharmaceutical services across Halton borough. As such it should continue to be used in the decisions around 'market entry' as well as local commissioning decisions of both Halton Clinical Commissioning Group and Halton Borough Council Public Health. Local groups and partnerships should also take the findings of the PNA into account when making decisions around the need for pharmaceutical services.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any legal challenges to decisions based on information in the PNA may open the HWB up to Judicial Review. This can have significant financial implications. It is therefore vital that the HWB continues to follow national guidance in the implementation of the Regulations.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and this should be reflected in the PNA, detailing service provision that is appropriate to this age group.

6.2 **Employment, Learning & Skills in Halton**
Not applicable

6.3 **A Healthy Halton**
All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**
Not applicable

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. Pharmacies provide a vital primary health care service to residents across the borough, are located within the heart of communities and offer open access to trained health professionals for advice on a wide range of issues.

7.0 RISK ANALYSIS

7.1 Failure to comply with the regulatory duties fully may lead to a legal challenge, for example, where a party believes that they have been disadvantaged following the refusal by NHS England over their application to open new premises based on information contained in the PNA.

7.2 The risk of challenge to the HWB who produced that PNA is significant and Boards should add the PNA to the risk register.

7.3 A sound process, using national guidance and with support from local expertise, should be established to ensure this risk does not materialise.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The PNA seeks to provide intelligence on which to base decisions about service provision that are based on levels of need across the borough. This includes analysis of a range of vulnerable groups and the need for targeted as well as universal services to meet the range of needs identified.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None within the meaning of the Act.

REPORT TO: Health & Wellbeing Board

DATE: 14 January 2015

REPORTING OFFICER: Simon Banks, Chief Officer

PORTFOLIO: Health

SUBJECT: General Practice Strategy

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To update the Health & Well Being Board on progress with the development of the General Practice Strategy and other key agenda's that influence the Strategy.

1.2 The purpose of this paper is to present the initial thoughts and concepts around the GP Strategy in Halton. It has been developed through local discussion, feedback and research.

1.3 This is a draft paper and it is recognised there are gaps in some areas that need to be completed.

2.0 RECOMMENDATION: That the Board is asked to note the contents of the report and timescales.

3.0 SUPPORTING INFORMATION

None

4.0 POLICY IMPLICATIONS

Five Year Forward View, Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority, 23rd October 2014, www.england.nhs.uk/ourwork/futurenhs/, accessed on 17th November 2014.

NHS England, *Prime Minister's Challenge Fund: Improving Access to General Practice*, NHS England, Gateway Reference 02356, www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/, accessed 17th November 2014.

5.0 OTHER IMPLICATIONS

None

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Children's Services will be an essential element of the future model of services as set out

6.2 Employment, Learning and Skills in Halton

The approach is designed to embrace and involve the broad spectrum of voluntary organisations across Halton

6.3 A Healthy Halton

The approach is designed to improve the health and wellbeing of the population of Halton.

7.0 EQUALITY AND DIVERSITY ISSUES

An equality Impact Assessment is due to be completed in January as part of the broader engagement and consultation approach.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

There are none within the meaning of the Act.

Background

1.1 Appendix 1 contains a draft document that sets out a summary of the draft General Practice Strategy that has been developed for Halton.

1.2 The document is still a work in progress and draft but outlines and identifies the key elements and concepts that are emerging as the strategy develops. The draft summary document has been shared with the practices and partners and formed the basis of a very productive discussion at the Service Development Committee in November.

1.3 This paper is designed to provide an update to the Health & Well Being Board of progress, as well as an update on the current work and next steps.

2. Strategic context

2.1 There a range of current national agenda's and drivers that will heavily influence and affect the development of the General Practice Strategy. These are:

- Five Year Forward View
- Co-commissioning
- Prime Ministers Challenge Fun

2.2 It is important to note that the development of the Strategy is being undertaken in full recognition and awareness of each of these. Furthermore, it is considered that the timing of the three drivers identified above, alongside the development of the General Practice Strategy presents an ideal time to integrate the approach with all four as they have the potential to optimise and compliment the effective delivery and effectiveness of one another.

3. Key elements of the strategy

3.1 There are four key elements to the General Practice Strategy:

3.2 Case for Change – setting out the range of national and local drivers that collectively result in the conclusion that General Practice in its current guise is not sustainable in Halton. This is evidence based and where available, local information and data has been used.

3.3 Principles - ten principles that are considered fundamental to the future design, configuration, commissioning and delivery of local General Practice.

3.4 Service model - it is proposed that a new model is established with services centred around people in the community, ensuring everyone's needs are met through an integrated health and social care delivery model. This will see GP practices working together in a much more integrated way with Community, Mental Health and Wellbeing, Social

Care, Urgent Care, Voluntary Sector and Pharmacy services all wrapped around local delivery points. This concept is described in the Five Year Forward View as a Multispecialty Community Provider (MCP).

3.5 Community Hubs - The model will see services and teams aligned to a community 'hub'. At present, there are 17 practices operating as 17 separate delivery organisations. This model is predicated on the practices starting to work together to create a number of community 'hubs', although the specific configuration of this will be for the General Practices and staff to determine. The aim is for each hub to contain approximately 20,000-25,000 residents, therefore, across Halton, there would be between 6-8 hubs.

4. Current position and next steps

4.1 There is a range of work underway at present including:

- 6 of the 7 workshops facilitated by NHS Improving Quality (NHSIQ) have been completed. The final workshop will take place on 13th January 2015;
- The draft document (Appendix 1) has been shared with practices and partners and feedback is being sought;
- On-going engagement work with practices, including consideration of hub configurations;
- Engagement work with the local population through PPG meetings;
- Running a co-design event with patients suffering from Cancer and Hypertension to use their ideas and experiences to agree actions that can improve access and services in Primary Care;
- Alignment of the approach with the Adult Community Nursing review that is running in parallel;
- Prime Ministers Challenge Fund application; and
- Co-commissioning application.

4.2 Work will continue through the actions outlined above. This will culminate in the development and presentation of the final strategy for the Governing Body in January 2015.

Appendix 1 - NHS Halton CCG General Practice Strategy. Summary document.

1) Introduction and background

"General Practice is often described as the cornerstone of the NHS, with roughly one million people visiting their general practice every day" (NHS England, A call to action, April 2014). Nine in every ten patient contacts are at GP surgeries. "Effective primary care enables improved health outcomes and lower costs" (Starfield at al, 2005; Atun, 2004).

However, the demands placed upon GPs and their teams have never been greater. Primary care sees more patients than ever, with more complex needs and greater expectations; it offers a wider range of services and it is seeking to maintain and improve ever higher standards of care. At the same time, the GP workforce is changing. Significant numbers of experienced GP principals are nearing retirement age, the GP workforce is becoming increasingly sessional and/or part-time, and many areas are experiencing difficulty with recruitment.

GP workload has increased from an average of 4 consultations per person, per year in 1995 to 5.5 consultations per person, per year in 2009 (HSCIC, 2012) and funding of General Practice as a percentage share of total NHS expenditure has reduced from 10.7% in 2005/06 to 8.4% in 2011/12 (GB)

Simultaneous to the collection of challenges described above, the NHS, like all public sector bodies, is considering the electoral policies being set out as we approach a general election in May 2015. A clear focus on the NHS, and more specifically General Practice, is evident from the emerging messages delivered in the 2014 autumn party conferences, whether that is about additional GP recruitment, extended General Practice opening times or the waiting times to access General Practice.

NHS England's 'Improving General Practice – A Call to Action' was a start to stimulate debate in local communities – amongst GP practices, area teams, CCGs, health and wellbeing boards and other community partners. It considers how best to develop general practice services and enable them to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better health outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources.

In response to 'A Call to Action' and to inform the challenges facing general practice and provide a sustainable future for membership practices, NHS Halton CCG has begun working with its member practices and key stakeholders to undertake a review of its services and their sustainability. To meet the increasing challenges faced, there is a need to reshape the range of services offered within general practice, thereby enhancing the sustainability of practices whilst preserving the local roots of general practice that are valued highly by patients.

This strategy describes how Halton CCG is working with its partners and the public to develop and commission standardised high quality General Practice that "…balance the benefits of organisational scale with preservation of the local nature of general practice" (The Kings Fund & Nuffield Trust, Securing the Future of General Practice, July 2013). This

document sets out a summary of the strategy and is intended to stimulate discussion and debate about the themes, proposals and approach set out.

2) National Drivers

It was essential to identify how the current and future national approach, as set out by NHS England, the current lead contractor for General Practice, was being considered.

In 'A Call to Action', Phase 1 report, NHS England set out five ambitions "…to improve services, both for today's population but also to ensure…excellent services for the future"

Five ambitions
• Proactive, co-ordinated care • Holistic, person centred care • Fast, responsive access to care • Health-promoting care • Consistently high-quality care

The document then sets out 7 areas of work where "…our area teams are working with local communities to translate the general ambition into specific concrete strategies for their populations. This reflects the different starting points and the different needs of communities; but it is within our overarching ambitions for improved outcomes for all.

"To support these locally-led transformations in primary care, we are focussing at national level on seven main areas of work"

Areas of work	Summary
Empowering patients and the public	Enabling patients and carers to play a more active role in their own health and care, involving local communities in shaping services, giving greater choice over the general practice they register with, and transforming patient access to GP services
Empowering clinicians	Ensuring high quality support for innovation and improvement, developing networks to allow more rapid spread of innovation, supporting General Practice in developing new models of provision, and releasing time for patient care and service improvement
Defining, measuring and publishing quality	Improving information about quality of services both to strengthen accountability to the public, clarity on what the public can expect, and to support clinical teams in continuous quality improvement
Joint commissioning	Working with CCGs to develop a joint, collaborative approach to commissioning General Practice services, with a stronger focus on local clinical leadership and ownership and allowing more optimal decisions about the balance of investment across primary, community and hospital services
Supporting investment and redesigning incentives	Supporting a shift of resources towards general practices and 'wrap around' community services, developing the national GP contract to support our five ambitions, and developing innovative new forms of incentives that reward the best health outcomes
Managing the provider landscape	Ensuring that all General Practices meet essential requirements, responding effectively to unacceptably low quality of care, and

	enabling new providers to offer their services to the public
Workforce, premises and IT	Working with national and local partners to develop the General Practice workforce, promote improvements in primary care premises and sustain improvements in information technology solutions

Commissioning for outcomes

A key strand to the strategy moving forward will be how practices and services are commissioned and contracted; this is where the CCG has identified the co-commissioning agenda as a real opportunity to commission services differently.

At present, practices have a number of funding streams that make up their total remuneration. The proposed approach is to work with practices to consider whether alternative contract and funding models can be developed locally to sit alongside the existing GMS/PMS contracts. At present, £xm is spend on enhanced services and £ym on QOF. Examples are being seen elsewhere in the country where these traditional funding approaches are being adapted to develop a more locally-orientated solution.

Such approaches could include commissioning for outcomes rather than processes or inputs, incentivising behaviours including peer review, leadership and responding to feedback and payments for improving access to services.

With the current direction of the co-commissioning agenda moving towards an even greater role for CCGs than first announced, i.e. full delegated responsibility for GP contracting, these options are wholly available to develop with the member practices, partners and NHS England.

3) The Case for Change

As at the 2011 Census, Halton's population was 125,700 (rounded to nearest 100) with 48.8% male and 51.2% female. The population registered with Halton GPs is 128,446 (July 2012) and there are 17 general practices in Halton.

Halton is ranked as the 27th most deprived local authority in England (out of 326 local authorities).

Life expectancy has risen steadily over time. In 2010-12 average life expectancy in the borough was 77.4 years for men and 80.7 years for women. However, the borough is consistently lower than its comparators (about 3 years lower than the England figures).

There are also internal differences in life expectancy, ranging from 71.1 years for males in Windmill Hill to 82.1 years in Daresbury. For females the differences range from 76.4 years in Riverside to 89.7 years in Birchfield ward: a difference of 10.4 years for males and 13.3 years for females

This is a slight narrowing of internal inequalities for men from 11.4 years and widening for women from 9.4 years during the previous reporting period 2008-10.

(Source: Halton JSNA, August 2013)

The table below summarises key demographic forecasts and changes:

Demographics Source: ONS Population Projections, 2014
• **The population in Halton will increase in size by 2.8% (3,500 people) between 2012 and 2030** • **Over this time period, the number of people aged over 80 will more than double (from 4,300 to 8,700) and the number aged between 65 and 80 will increase by over 40%** • **During the same time period, this will see a reduction of 3.8% in the under 19 population and a reduction of 8.6% in the 20-59 population**

Long Term conditions and co-morbidities

The table below presents the headline figures of QOF prevalence in Halton against six key QOF disease groups. It demonstrates the prevalence rates compared to the England average and also highlights variation in the levels of prevalence across the GP practices in Halton:

Condition	Halton average	England average	Halton maximum	Halton minimum
Asthma	6.9%	6.0%	9.7%	5.6%
CHD	4.4%	3.3%	5.0%	2.4%
Diabetes (over 17)	7.3%	6.0%	8.0%	4.1%
COPD	2.5%	1.7%	4.0%	1.5%
Hypertension	14.8%	13.7%	17.6%	8.8%
CKD (over 17)	4.5%	4.3%	5.8%	2.5%

Source: Quality Outcomes Framework 2012/13

According to results from the national 2009 General Lifestyle survey, people with long term conditions account for:

- 50% of all GP appointments;
- 64% of outpatient appointments;
- 70% of all inpatient bed days;
- In total around 70% of the total health and care spend in England (£7 out of every £10) is attributed to caring for people with LTCs;
- This means that 30% of the population account for 70% of the spend.

Source: 2009 General Lifestyle Survey

In a consultation response from people living with long term conditions, they said:

- They want to be involved in decisions about their care – they want to be listened to;
- They want access to information to help them make those decisions;
- They want support to understand their condition and confidence to manage – support to self-care;
- They want joined up, seamless services;

- They want proactive care;
- They do not want to be in hospital unless it is absolutely necessary and then only as part of a planned approach;
- They want to be treated as a whole person and for the NHS to act as one team.

Source: Our health, our care, our say: a new direction for community services – consultation responses from people with long term conditions

In the Department of Health's Long Term Conditions Compendium of Information (Third Edition, May 2012), it sets out "Age is a major factor in prevalence of LTCs but also in those who have multiple LTCs" and also that "The number of people with one long term condition is projected to be relatively stable over the next ten years. However, those with multiple LTCs is set to rise to 2.9 million in 2018 from 1.9 million in 2008."

This is based on a national population forecast that "By 2034 the number of people aged 85 and over is projected to be 2.5 times larger than in 2009, reaching 3.5 million and accounting for 5% of the population."

It sets out that "The additional cost to the NHS and social care for the increase in co-morbidities is likely to be £5 billion in 2018 compared to 2011. Plans need to be put in place now to address the health and social care issues facing people with multiple long term conditions."

Patient experience

The feedback from the national General Practice patient survey published in July 2014 set out that the general satisfaction of respondents locally was lower than the national average and peer group (industrial hinterland) average against a number of the questions.

Patient experience
Source:

- **Q, Overall experience of making an appointment. Answer - Very good**
  Halton - 24%, Eng av – 34%, Peer av – 32%
- **Q, Ease of getting through to someone at GP surgery on the phone. Answer – Very easy**
  Halton – 15%, Eng av – 26%, Peer av – 25%
- **Q, Is the GP surgery currently open at times that are convenient for you? Answer - Yes**
  Halton – 72%, Eng av – 75%, Peer av – 77%
- **Additional opening times that would make it easier to see or speak to someone:**
  After 6:30 – 73%, On Saturday – 73%

However, within the first three questions presented above, there was wide variation in the satisfaction response rate between practices:

Questions	Halton av.	Halton max.	Halton min.
Overall experience of making an apt – very good	24%	80%	14%
Ease of getting through to someone at GP	15%	75%	3%

surgery on the phone – very easy			
Is the GP surgery currently open at times that are convenient for you? Yes	72%	94%	56%

Urgent care rates

The Advancing Quality Alliance (AQUA) Quality and Efficiency Scorecard for Frail Elderly (June 2014) sets out that the Non-Elective admissions aged 65+ per 1000 population in Halton are in the top 19-23 quartile (where a lower rate is considered better) for CCGs across the North West. The average NW admission rate was 295 per 1000 population and the Halton rate was 319.

Looking at similar data (for the over 75s population), the average admission rate in Halton for the over 75s population is 412 per 1000 population. However, there is a significant variation in the levels between practices with the lowest admission rate at 279 per 1000 population and the highest admission rate at 647 per 1000 population.

Referral rates

Data provided the acute providers identify the GP referral rates from 2013/14 for all specialties. It demonstrates that average referral rate per 1000 weighted population across all practices was 179. However, there is significant variation at a practice level with the highest level at 310 referrals per 1000 weighted population and the lowest level at 111 per 1000 weighted population.

Practice variation

There is a range of information available that demonstrates variation across General Practice. Variation can be a positive reflection of decision-making and services aligned to the needs, desires or expectations of a specific population and individual.

There are also instances of unwarranted variation and the causes of this include:

- Variation in the supply of resources, more facilities in one population than another;
- Different definitions of appropriateness for intervention and referral, either by individual clinicians, sometimes even within one institution, or between different groups of clinicians working in the different populations;
- Variations that may be due to attitudes, both individual and population based, for example differences in use of services to different ethnic groups or different age groups. The Inverse Care Law was first described in 1971 and indicates that care may be provided inversely in relation to need because of beliefs and attitudes both on the part of the population itself and professionals serving it.

Source: Unwarranted variation (September, 2011)

No conclusions have been drawn from the above information, other than the demonstration of variation across the practices. Part of the strategy moving forward will be a need to clarify the difference between warranted and unwarranted variation and where unwarranted, consider interventions to reduce it.

Interventions for dealing with variation in clinical practice include:

- Peer review and audit between practices;
- Point of care decision support systems, prompts and reminders;
- The use of explicit care pathways;
- The use of information technology;
- The use of guidelines and audit to measure adherence to guidelines.

Workforce

Data sourced from the Health and Social Care Information Centre demonstrates that as of 30th September 2013, Halton had the following number of GPs (excluding Registrars and Retainers):

Full Time Equivalent

Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	Total
2	9	9	9	10	8	12	5	1	66

This demonstrates that 27.1% of current practitioners in Halton are 55 and over.

Furthermore, according to the Seventh National GP Work life Survey by Hann et all, 2013, University of Manchester, an increasing number of GPs (nationally) are considering their 'Intention to Quit' within the next five years

Considerable/high intention to leave direct patient care within five years	All GPs	GPs aged under 50	GPs aged over 50
2005	19.4%	6.1%	41.2%
2008	21.9%	7.1%	43.2%
2010	21.9%	6.4%	41.7%
2012	31.2%	8.9%	54.1%

Forecast future demand

In May 2014, Capita (commissioned by four local CCGs) produced an End to End Care Assessment Report designed to provide a retrospective, current and future view of health and social care activity, spend and patient flows across the Mid Mersey area.

They set out that the CCG operates within "a complex health environment – Community and Mental Health services are provided…by two main Trusts (Bridgewater Community Healthcare and 5 Boroughs Partnership) – however, while the provision of acute secondary care is dominated by St Helens and Knowsley Trust and Warrington and Halton NHS FT, there is a significant amount of competition from specialist NHS providers on Merseyside as well as local private hospitals".

Based on population forecasts alone, the "Do nothing" scenario when considering the financial implications across the four main care settings for the CCG are set out below:

Care Setting	% change	% change	% change

	to 2016/17	to 2018/19	to 2023/24
Acute	+3.2%	+5.2%	+10.2%
Community	+2.5%	+4.0%	+7.7%
Mental Health	+2.5%	+4.0%	+7.7%
Social Care	+2.5%	+4.0%	+7.7%

Financial overview of General Practice

As set out in the introduction and background sections, funding of General Practice as a percentage share of total NHS expenditure has reduced from 10.7% in 2005/06 to 8.4% in 2011/12 (GB).

NEED TO ADD LOCAL DETAILS

4) Local commissioning response

Having considered the information and evidence available and through a process of engagement with member practices and stakeholders, the conclusion was reached that **General Practice in Halton is not sustainable** in its current guise.

Halton commissioning principles and response

To address the range of issues outlined in the case for change section, the problem statement and to embrace the ambitions and areas of work set out by NHS England, Halton CCG believes the following ten principles are fundamental to the future design, configuration, commissioning and delivery of local General Practice:

- Commissioning and delivering consistent high quality care for every local resident;
- Care continuity for patients with Long Term Conditions;
- Reducing unwarranted variation;
- Strong local clinical leadership;
- Embracing the opportunity to offer services at scale, delivered locally to individual people;
- High levels of population and patient engagement;
- Commissioning and contracting for outcomes, not inputs or processes;
- Services working in greater collaboration in the community as multi-disciplinary teams of care professionals working together;
- Improving access to all services and better coordination of care pathways;
- Focus on prevention.

5) Integrated model

To achieve this, it is proposed that a new model is established with community services centred around people, ensuring everyone's needs are met through an integrated health and social care delivery model. This will see GP practices working together, in a much more integrated way with Community, Mental Health and Wellbeing, Social Care, Urgent Care and Pharmacy services all wrapped around local delivery points.

The diagram below sets out this approach:

What potential benefits will this integrated approach bring…for patients?

- Better and clearer access to local health and social care services;
- Better co-ordination of care, especially for elderly patients, patients with complex needs and those with Long Term Conditions;
- Improved experience;
- Improved communication and information;
- Reduced duplication;
- Reduced number of unplanned admissions

What potential benefits will this integrated approach bring….for professionals?

- Better access to local services and experts for their patients;
- Increased level of peer support and access to expertise;
- Reducing unwarranted variation within services;
- Better opportunity to lead and influence commissioning decisions and strategy for the local population;
- Reduction in crisis management;
- Opportunity to offer more services at scale whilst maintaining local presence;
- Reducing pressure on the workforce;
- Improved use of technology;
- Increased financial sustainability.

Multi-disciplinary team working

The model will see the following services and teams aligned to each community 'hub':

Community nursing	**School nursing**	**District nursing**
Community midwives	**Health visitors**	**Social care services**
Mental health teams	**Well-being services**	**Sexual health services**
Health improvement teams	**Urgent Care Centres**	**Family nursing**

Each 'hub' will determine how to best configure itself to meet the needs of its local population. This includes service delivery, governance, population engagement, performance management and strategic planning. It is recognised that in certain

circumstances, it will be advantageous to continue to commission and deliver services across the whole borough of Halton, however, this will be for each 'hub' to determine and influence.

At present, there are 17 practices operating as 17 separate delivery organisations. This model is predicated on the practices starting to work together to create a number of community 'hubs', although the specific configuration of this will be for the General Practices and staff to determine.

An integrated team approach will see care professionals from each organisation and service identified aligned to one of the 'hubs', therefore, operating 17 'hubs' would not be viable with the resource available, whether that be staffing numbers or financially.

Priority areas of focus

As well as considering the organisational forms, it has been essential to consider which areas, when further addressed, would have the greatest impact on the population's health. When considering commissioning for outcomes, it was essential to identify and work on the areas with the highest priority for the local population and the Halton Public Health team have supported this process:

As a result, the following have been identified as priorities.

Area	Rationale
Mental illness	Highest cost to NHS, largest contribution to disability adjusted life years (DALYs) lost in Halton; 4th largest contribution to local mortality
Cancer and CVD	Two largest causes of premature mortality; 2nd and 3rd biggest contributor locally to DALYs lost., 1st and 2nd largest cause of potential years of life lost (PYLL) inequalities gap
Unplanned/urgent care	High rate of 30 day re-admissions
Hypertension	Largest disease register and biggest prevalence gap
Gastrointestinal including liver disease	Worst rate of premature mortality, 4th largest contribution to PYLL, inequalities gap
Respiratory disease	Large cause of hospital admissions, 4th largest contributor to disability and 3rd to mortality locally, 3rd for PYLL, inequalities gap
Accidents	Inequalities gap, Halton is an outlier for children's accidents, inequalities gap- listed under 'external causes 'on life expectancy gap tool

It is acknowledged that analysis will be undertaken with each 'hub' to determine the priority areas for each as they will not be the same across the whole borough. The solution to tackling each area will be for the community hub to determine. The principles of sharing experience and peer review to identify best or successful practice will be encouraged.

It is proposed that 'Action Teams' are established (where not already in place) to focus on each area identified to determine and set appropriate outcome and performance levels and service standards.

Initial working groups

As part of the work to date with the GP Strategy, four areas have been identified where work has begun. These areas are:

- Cancer;
- Hypertension;
- Access to services over 7 days;
- Care Homes.

Further groups will need to be established to ensure all areas identified above are appropriately considered and addressed. It is essential that any new or emerging working areas are aligned to existing projects or programmes of work to avoid duplication and confusion.

Future practice operating models

In response to the approach set out, it is recognised that a number of organisational types exist that practices may want to consider moving forward including:

- The current as-is model;
- Networks or federations;
- Super-partnerships;
- Regional multi-practice organisations;
- Community Health organisations.

Aside from the 'as is' approach, all of these models are "defined by their desire to use greater organisational scale to extend the range of services offered and to diversify income streams, thus enhancing the sustainability of practices. They develop more sophisticated management support to undertake strategic planning and service development, and create new professional, management and leadership roles that offer a new range of career opportunities for professional, managerial and support staff in primary care. It is striking that despite their differing originals and philosophical underpinning, the models of care share a desire to improve and extend primary care services, develop management and leadership capacity, and assume a more significant role in the local health system.

"Critically, they all emphasise the need to balance the benefits of organisational scale with preserving the personal and local nature of general practice. Each of the 'at scale' primary care models…had preserved local practices as the first point of contact for patients, strengthened network of wider advice and support available, and used organisational scale to enhance (and not undermine) the local accessibility and nature of primary care" (Securing the future of general practice, Kings Fund & Nuffield Trust, July 2013)

6) Enabling support

In addition to the commissioning priority areas, there are four underpinning key enablers that the CCG will drive forward to support a sustainable solution. The areas are:

- Workforce
- Estates
- IT and Informatics
- Contracting

Each of the four areas brings its own challenges and opportunities. Working with General Practice and the experts in each area, the CCG will develop a long term approach to each that will support the development and evolution of services.

Workforce

A paper was presented in October 2014 to the Service Development Committee (SDC) setting out the principles of workforce planning. It also stimulated discussion and debate with General Practice around the need to undertake a Halton-wide approach to workforce planning. There was collective recognition of the challenges described in the paper (as well as in this document) and an agreement that further discussions are needed to consider what can be done to address the range of issues.

Essential to those further discussions is the consideration of how the future model of service delivery will affect and influence both the current and future workforce needs, including staffing numbers, staffing types and skill mix.

Estates

Working with local partners and considering the future model of service delivery, the intention of the Strategic Estate Planning process is to support real change in the local estate and to generate strategic estate solutions that drive system wide savings, integration and new service models. Significant savings are achievable through a structured and targeted programme to support the strategic planning of the estate, which will deliver:

- **Increased efficiencies**, through the better use of high-quality primary and community care estate.
- **Better service integration**, driving improvements in service efficiency and better health outcomes for patients.
- **New service models**, supporting the drive to move services into the community from hospitals, replacing outmoded and inadequate premises and releasing capital through a structured programme of disposals.

Information Management and Technology (IM&T)

An IM&T strategy is being developed to reflect the overall strategy, values and aspirations for the future and highlights how Health Informatics and IT can be a significant enabler and driver of improved information flows. This will help effectively measure what we do now, how we communicate and most importantly, how to improve it. It is ensuring that fit for purpose systems are in place which allows streamlined processes and data sharing supported by robust governance arrangements to support clinicians to provide high quality care.

The strategy is designed to focus on the opportunities and innovation that Information Technology and information/data management can offer and will set out how the CCG, practices and partners can deal with rapid changes both in respect of the internal and external environment.

We must ensure that the use of information and information technology to improve patient care, access to care, the patient experience, delivery of clinical outcomes, health record keeping and value for money should be, and will be, a fundamental part of all future of General Practice.

Contracting

To support a number of points made above, it is recognised that "…a new alternative contract for primary care is required (in parallel to the current General Medical Services contract). The contract needs to be crafted by NHS England in a way that encourages groups of practices to take on a collective responsibility for population health (and ideally also social) care across a network of practices, without specifying the detail of implementation – this should be a matter for local determination" (The Kings Fund & Nuffield Trust, Securing the future of general practice, July 2013)

CCG support

In addition, to support the delivery of the strategic vision described for General Practice, it is recognised that the CCG will need to:

- Configure itself to ensure it embraces the opportunities presented by co-commissioning;
- Support the development of community 'hub's;
- Support practices as they consider alternative approaches to working together;
- Support the development of a Commissioning for Outcomes commissioning and contracting approach;
- Support the development of the workforce planning, estates and IM&T strategies;
- Align and integrate the approach within the existing governance arrangements of the CCG.

7) Conclusion

This paper is designed to summarise the key themes and elements included within the General Practice Strategy for Halton CCG. A lot of the content has been derived from conversations with General Practice over recent months.

REPORT TO: Health & Wellbeing Board

DATE: 14th January 2015

REPORTING OFFICER: Simon Banks, Chief Officer

PORTFOLIO: Health and Wellbeing

SUBJECT: Prime Ministers Challenge Fund

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To inform the Health & Well Being Board of Wave Two of the Prime Minister's Challenge Fund: Improving Access to General Practice and of the submission being co-ordinated by NHS Halton CCG.

2.0 RECOMMENDATION: That the Board

(1) note the contents of the report and timescales; and

(2) consider any risks not identified and potential mitigations

3.0 SUPPORTING INFORMATION

A successful application to the Prime Minister's Challenge Fund would enable resources to be utilised to deliver improvements in general practice services, which is congruent with our commissioning strategy and plans.

4.0 POLICY IMPLICATIONS

Five Year Forward View, Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority, 23rd October 2014, www.england.nhs.uk/ourwork/futurenhs/, accessed on 17th November 2014.

NHS England, *Prime Minister's Challenge Fund: Improving Access to General Practice*, NHS England, Gateway Reference 02356, www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/, accessed 17th November 2014.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**
Children's Services will be an essential element of the future model of services. The Challenge Fund will support more rapid implementation

5.2 **Employment, Learning and Skills in Halton**

The approach is designed to embrace and involve the broad spectrum of voluntary organisations across Halton. The Challenge Fund will support more rapid implementation

5.3 **A Healthy Halton**

The approach is designed to improve the health and wellbeing of the population of Halton. The Challenge Fund will support more rapid implementation.

6.0 RISK ANALYSIS

An unsuccessful application will not stop the implementation of the General Practice strategy, however, it has the potential to slow it down.

7.0 EQUALITY AND DIVERSITY ISSUES

An equality Impact Assessment is due to be completed in January as part of the broader engagement and consultation approach.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

There are none within the meaning of the Act.

PRIME MINISTER'S CHALLENGE FUND: IMPROVING ACCESS TO GENERAL PRACTICE, WAVE TWO

1. Background

1.1 In October 2013, the Prime Minister announced a new £50 million Challenge Fund to help improve access to general practice and stimulate innovative ways of providing primary care services. Twenty pilot schemes have been selected that will benefit over 7 million patients across more than 1,100 practices.

1.2 On 30 September 2014, the Prime Minister announced a new second wave of access pilots, with further funding of £100m for 2015/16. The Government has asked NHS England to lead the process of inviting practices to submit innovative bids and overseeing the new pilots.

1.3 The pilots will explore a number of ways to improve access including:

- longer opening hours, such as 8am-8pm weekdays and opening on Saturdays and Sundays;
- joining-up of urgent care and out-of-hours care;
- greater flexibility about how people access general practice;
- greater use of technology to provide alternatives to face-to-face consultations eg via phone, email, webcam and instant messaging;
- greater use of patient online services; and
- greater use of telecare and healthy living apps to help people manage their health without having to visit their GP surgery as often.

1.4 NHS England is inviting applications from practices or more likely, groups of practices that wish to test new models for providing general practice services, with potential benefits not only for patients accessing general practice, but also with benefits to the wider NHS. NHS Halton CCG is working on an application with the local practices, partners and CCG staff and will be liaising closely with Merseyside Area Team over the coming weeks to get their input and considerations to ensure the application is as robust as possible.

2. The selection criteria

2.1 The following are the key requirements that will be used to review local bids. Practices should be able to:

- demonstrate that patients will be able to access general practice services from 8am-8pm on weekdays (or equivalent) and improved access at weekends. *This will be a minimum condition of funding being provided to wave two pilots;*

- respond to local patient insight, preferences and priorities, with a clear goal of improving patient experience of access, as measured through the GP Patient Survey;
- support the local health and wellbeing strategy;
- be sustainable beyond the life of the pilot scheme;
- cover as a minimum a population of 30,000, and no bigger than a CCG population (unless exceptional circumstances apply);
- demonstrate strong leadership and commitment/buy-in from all practices involved; and
- be able to implement rapidly.

2.2 In addition, every pilot should demonstrate the potential for a wider range of benefits, to include:

- a more integrated approach to providing general practice and wider out-of-hospital services, including 'wrap-around' community services such as community nursing, community pharmacy, diagnostic services and voluntary sector provision;
- a more integrated approach to providing urgent care services across a local health economy; connect with hospital plans for delivering seven day services; and
- more innovative ways for people to access and relate to general practice, including for children and young people and from groups that find it hard to access general practice.

3. Funding

3.1 The Government has provided £100 million of programme funding for 2015/16 to support this pilot programme. This will be used non-recurrently to support sustainable changes beyond the lifetime of the pilots.

3.2 A large proportion of the fund will be spent on new pilots looking at innovative ways of improving access to general practice. Funding will also build on the learning from Wave One so some of the fund will be used for evaluation, development and strategic IT support.

3.3 NHS England are inviting applications from practices that include funding proposals and will make final decisions on the number of sites based on the applications received and dialogue with applicants to help gauge the level of support they require. Possible uses of funding may include, but would not be restricted to:

- external support for change management, programme and project management (including for data management and extraction linked to the evaluation) and organisation development;
- external support, including any legal costs, for work involved in exploring new organisational models to support improved access;

- improvements to information management and technology (IM&T) systems. We may look to undertake some of these improvements at scale across several pilots, in order to secure best value for money; and
- training and development costs.

3.4 Whilst it is essential that funding is used on a non-recurrent basis, applicants may put forward proposals for pump-priming funding to reflect additional service costs, where:

- there is a strong business case to show that the service changes are likely to release funding that would allow this investment to be sustained beyond the period of the Challenge Fund; and
- where there are clear plans to monitor this financial impact.

4. Application process

4.1 As part of the process, NHS England area teams will review links to local strategy and local leadership capacity and capability. Prospective applicants have been encouraged to discuss their plans with area team(s) and CCGs before submission.

4.2 All successful pilots will be expected to participate in the national evaluation.

4.3 The key milestones are:

- Launch wave two bidding process w/c 27 October 2014
- Deadline for wave two applications 5pm, 16 January 2015
- Announce successful wave two pilots February 2015
- Pilot mobilisation March onwards

4.4 Applicants should submit a completed application form (available at NHS England website) by 5pm Friday 16th January to: england.challengefund@nhs.net copied to your area team.

5 Approach in Halton

5.1 The main emphasis of the application is the development and implementation of the emerging General Practice Strategy. However, where practices have ideas about specific projects or schemes that dovetail with this, we are actively working with them to encapsulate them within the single application.

5.2 A number of practice staff, partners and CCG staff have volunteered to support the development of the application form. The aim is to have a first draft of the application completed in November and this will then be amended and developed throughout December with the help of the volunteers. Sign off will then take place in January ahead of the submission on 16th January 2015.

5.3 As well as focussing on the development and implementation of the General Practice Strategy, we will also be concentrating on the development of IM&T solutions and engagement and insight activities that are seen as critical enablers to the success of the overall work programme.

5.4 We will also be setting out an innovative approach to pharmacy services and are actively discussing support with the National Pharmaceutical Association who are keen to support the ideas we have in Halton.

5.5 Discussions are also taking place with the North West Coast Academic Health Science Network (AHSN) about potential input and support around the telehealth and telemedicine agendas.

5.6 Finally, the inextricable link with the opening of the Urgent Care Centres will feature within the application. We are planning to set out a twin approach to our response to the emerging extended access agenda. At a local/community level, we will work with practices and groups of practices to consider any ideas or solutions they have and have some interesting solutions developing. Running in parallel will be the broader town-based approach where the opening of the Urgent Care Centres will offer a significant boost in community capacity to meet the primary care needs of the local population away from the hospital setting.

6 The application

6.1 As well as the standard background information that is needed, there are some particular areas of focus that we must consider within our application. These include:

- Project outputs – describing the benefits to our patients and population
- Sustainability – how we will sustain improvements once the non-recurrent funding is no longer available
- Link to local strategy for the health and care system – ensuring the approach aligns within the overall context of reform for the local community.
- Engagement – how local people and practices have been involved in designing the solutions and programmes
- Capacity and capability for rapid implementation – demonstrating that we have the capacity and skills to implement the projects we set out within 2015/16
- Leadership – demonstrating clear leadership and commitment from general practice
- Improvement methodology – how we will redesign services and undertake testing and refinement of innovative ideas.

7 Next steps

7.1 The General Practice Strategy Programme Lead will continue to coordinate the development and completion of the application form, engaging with practices, partners and colleagues throughout.

7.2 The aim is to ensure that before Christmas, a final draft is completed, providing sufficient time to finesse the final version before submission. Whilst there were 20 successful CCGs bids in Wave 1, it is felt that there will be increased competition with a greater number of applications in Wave 2, therefore, an application in itself does not guarantee success.

7.3 Whilst non recurrent money is not essential for every element of the implementation of the General Practice Strategy, it will undoubtedly help and can be used to pump prime a number of schemes and projects. To this end, conversations are on-going with other agencies and organisations to identify other pots of non-recurrent monies that could potentially be bid for if the application for the Prime Ministers Challenge Fund is unsuccessful.

REPORT TO: Health and Wellbeing Board

DATE: 14th January 2015

REPORTING OFFICER: Strategic Director Children and Enterprise

PORTFOLIO: Children, Young People and Families

SUBJECT: Children in Care Annual report

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Annual Report on the Health of Children in Care 1st April 2013 – 31st March 2014.

2.0 RECOMMENDATION: That the Health and Wellbeing Board note the report.

3.0 SUPPORTING INFORMATION

3.1 The Children In Care Annual Report (Attached in Appendix 1) looks at the health issues of Children In Care (CIC) in Halton and Children In Care from Other Local Authorities who live in Halton (CICOLAS).

3.2 The report has been provided by Marie Fairbrother, who is the Named Nurse Halton Safeguarding Children from Bridgewater Community Healthcare. Bridgewater health care practitioners are commissioned by Halton Clinical Commissioning Group (CCG) to deliver safe and effective care to CIC which is measured by key performance indicators. Service delivery in Bridgewater is also monitored by the Care Quality Commission.

3.3 Service delivery is underpinned by the Department of Health (2009) 'Statutory Guidance on Promoting the Health and Well-being of Looked After Children'. Also guidance produced by NICE (2010) "Promoting the Quality of Life of Looked after Children and Young People".

3.4 When a child or young person comes into care they have a health assessment by the Community Paediatrician (a doctor who works with children and young people). Some children and young people when they enter care are not always up to date with health checks and immunisations (which protect them from serious illness) or may not have been to the dentist so we want to make sure that they catch up with anything they have missed.

3.5 Once they have seen the doctor, the children and young people will each have a nurse who will see them later in the year for health checks and help them with their health care plan. The Children in Care Nurse will also see all Care Leavers for a health check before they leave care.

3.6 The report concludes that there has been considerable improvement in children receiving a timely service to ensure that their health needs are identified and addressed. However there is still room for improvement and healthcare partners need to continue to work together, to ensure that CIC are offered a service of the highest quality to meet each child/young person's needs.

4.0 POLICY IMPLICATIONS

4.1 The policy implications are addressed below.

5.0 OTHER IMPLICATIONS

5.1 None

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**
Addressing the health needs of Children In Care is an essential part of the care provided to Looked after Children and Young People.

6.2 **Employment, Learning and Skills in Halton**
Looking after the health needs of children In Care will help to ensure that they remain healthy and are therefore less likely to require time away from education or training.

6.3 **A Healthy Halton**
It is essential that the health needs of Children in Care are assessed when they come into care, throughout their time in care and upon leaving care to ensure that any health needs are identified and met.

6.4 **A Safer Halton**
None

6.5 **Halton's Urban Renewal**
None

7.0 RISK ANALYSIS

7.1 If children and young people are not assessed to ensure that their health care needs are met, then there is the risk of health problems going undetected and possibly deterioration in their health.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Some children and young people when they enter care may have health inequalities as they are not always up to date with health checks and immunisations or may not have been to the dentist. It is therefore essential that they catch up with anything they have missed.

.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

There are none within the meaning of the Act.

Bridgewater Community Healthcare NHS
NHS Trust

Report on the Health of Children in Care

1st April 2013 – 31st March 2014

Author

Marie Fairbrother

Named Nurse Halton Safeguarding Children

Bridgewater
Healthcare at the heart
of your community

CONTENTS

1. Introduction

This is the Children in Care (CIC) Annual Health Report to the Bridgewater Community Healthcare NHS Trust Board, the Children in Care Partnership Board and Halton Safeguarding Children Board. Following re-organisation within Bridgewater the Named Nurse Safeguarding Children for Halton assumed management responsibility for the CIC Nursing team on 1st October 2013. The CIC team are now part of the Safeguarding Children Nursing team in Halton.

As a result of the change in management this report will focus primarily on the period of activity in relation to service provision between 1st October 2013 and 31st March 2014. The number of CIC in Halton has significantly increased over a 2 year period from a low in end March 2012 of 124 children to **213** end March 2014. The number of Children in Care from other local authorities remains fairly static at **150 - 160**.

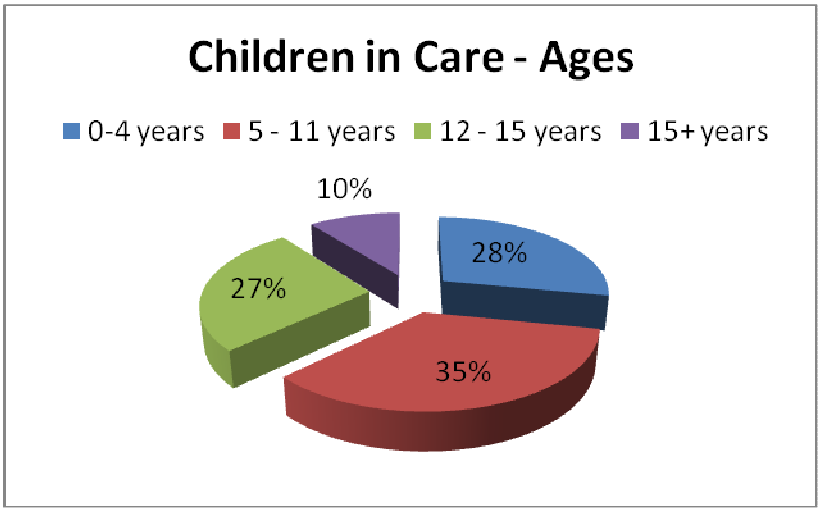
Service delivery is underpinned by the Department of Health (2009) " Statutory Guidance on Promoting the Health and Well-being of Looked After Children". Also guidance produced by NICE (2010) "Promoting the Quality of Life of Looked after Children and Young People".

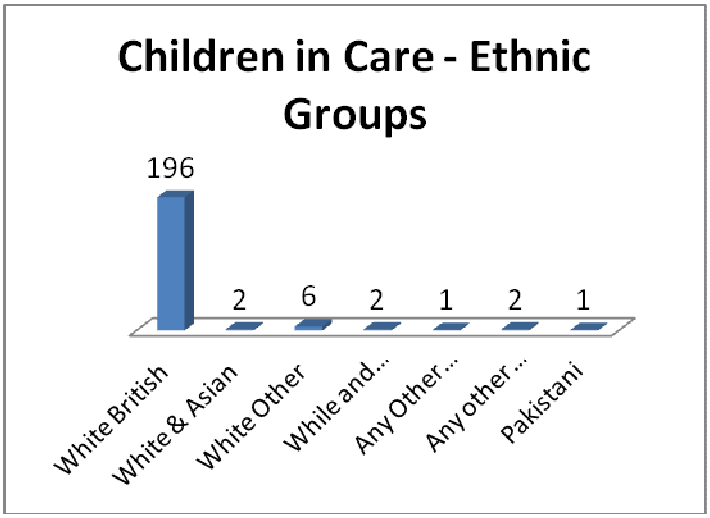
Bridgewater health care practitioners are commissioned by Halton Clinical Commissioning Group (CCG) to deliver safe and effective care to CIC which is measured by key performance indicators. Service delivery in Bridgewater is also monitored by the Care Quality Commission.

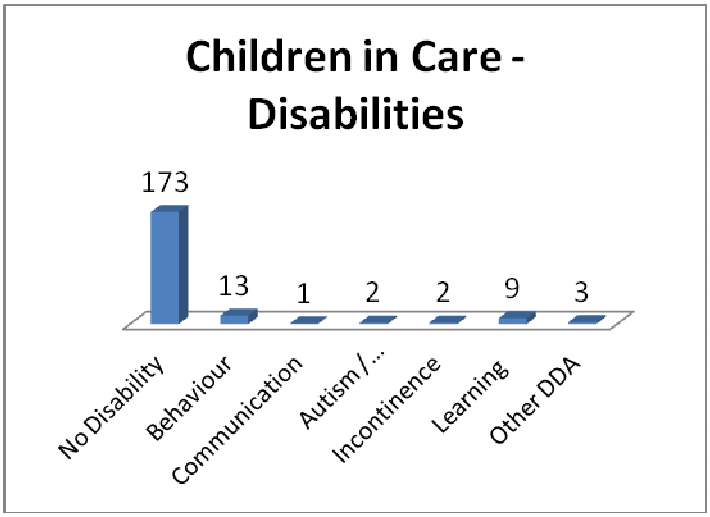
This report includes information regarding CIC placed by Halton Borough Council and also children and young people placed within Halton boundary by other local authorities.

2. Profile of Children in Care in Halton

The CIC population varies from day to day however in quarter 4 out of **210** children **93** were **male and 117** were **female.** The average age for coming into care was **6.63 years** an increase in age profile from **5.79 years** on the previous year.







The majority of the children (**130**) were placed in foster care. In relation to ethnicity, **196** out of **210** children are white British. **173** children out of **210** had no recorded disability.

3. Roles and Responsibilities of Health Practitioners

The CIC Nurse and administrator are now based in Lister Road, Runcorn with the Safeguarding Team. This has benefited CIC as the CIC Nurse now provides a service exclusively for children and young people in Halton Borough.

The Safeguarding Children Senior Administrator is now the line manager for the CIC administrator and has oversight of all the administration systems and

processes within our team. This ensures that CIC team are able to monitor service delivery effectively and that the organisation fulfils its statutory obligations to CIC.

The CIC Nurse ensures that Children in Care have their health needs identified through the assessment process. This is achieved through having oversight of the health assessments and health plans and undertaking a quality assurance role in respect of service delivery.

The CIC Nurse has a significant caseload of over 50 CIC including Care Leavers, young people over 16 years, children in alternative education provision and Children in Care from other local authorities (CICOLA's) who do not receive a service from a Health Visitor or School Nurse. Safeguarding supervision is provided to the CIC nurse by the Nurse Specialists Safeguarding Children within the team.

The CIC Nurse acts as a health advisor to CIC, social workers, foster carers and also to other health professionals. The CIC Nurse undertakes a facilitative role between Health services and Children's Social Care in Halton and throughout the country when required to do so. The CIC nurse also delivers training to health practitioners, social workers and foster carers.

The CIC nurse attends the regional North West Health Care Partnership Meeting the function of which is to share and disseminate good practice in relation to CIC.

As a member of a larger Safeguarding Nursing team the CIC Nursing team receive additional support. The Named Nurse Safeguarding Children is the line manager for the CIC Nurse. Also the Named Nurse has management oversight of service delivery and undertakes a quality assurance role on behalf of the organisation to ensure that CIC receive a quality health service from Bridgewater practitioners.

4. Community Paediatricians

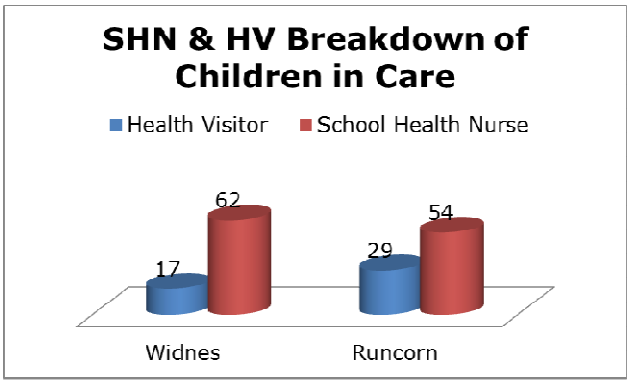
In Halton, Initial Health Assessments (IHA's) are undertaken by the Community Paediatricians. At the IHA a health plan will be formulated and should include

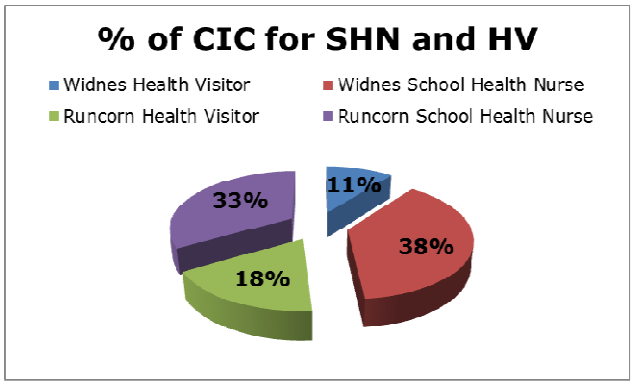
the voice of the child. IHA's should be undertaken within a statutory requirement of 28 days of a child coming into care.

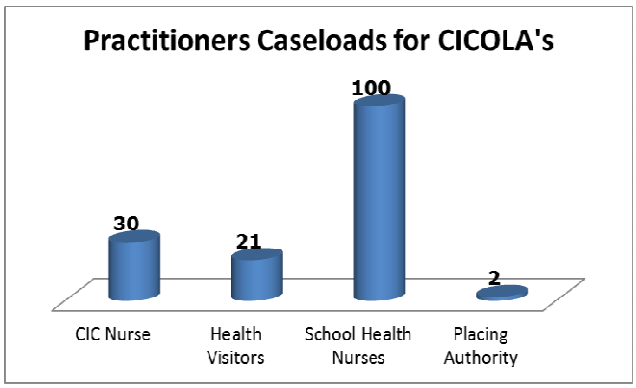
5. Health Visitors and School Nurses

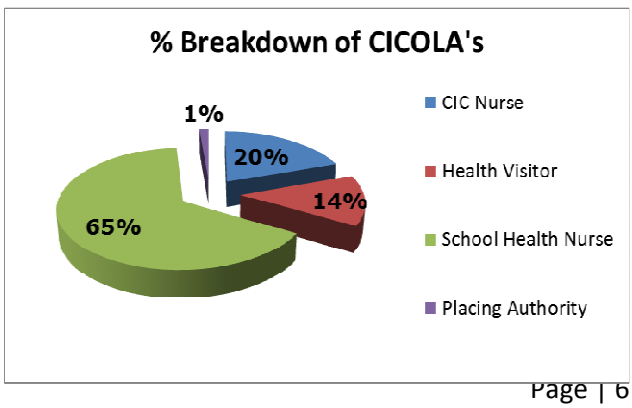
Review Health Assessments (RHA's) are undertaken pre-school by Health Visitors every 6 months. School age and over 5's are done by School Nurses annually. (See charts showing distribution of CIC and responsible practitioner) However these assessments will be undertaken/reviewed more frequently if any health needs are identified. The voice of the child/young person is captured in the review health assessment.

Statutory health assessments are important and research suggests that they identify health need and health neglect that might have otherwise gone unrecognised (DOH 2009). In Halton the Safeguarding team are seeking to improve health outcomes for CIC by close monitoring of health needs and a child's journey through the health system. This is achieved through scrutiny of health assessments which undergo a quality assurance process. This entails the identification of health need and tracking of health outcomes for each child or young person. Also included is the delivery of safeguarding supervision to health practitioners by the Nurse Specialists Safeguarding Children for all CIC.









6. Activity from 1st April 2013 – 31st September 2013

An audit of CIC IHA health assessment process was undertaken by Cheshire and Merseyside Commissioning Support Unit at the request of Bridgewater in September 2013. The audit considered data from April 2013 until July 2013 and examined the time-frame from the notification of a child coming into care to the production of the Initial health assessment report for the child's social worker.

The audit identified room for improvement in the communication process between Children's Social Care and Bridgewater health practitioners. This would allow for a more timely notification from Children's Social Care of a child coming into care which was on average **39** days. As a result of this delay no initial health assessments were completed within timescales. The audit also highlighted the time taken for a completed IHA report to be sent to Children's Social Care which was on average **23** days.

A further audit was undertaken by the Named Nurse in October 2013 to look at the whole process including both initial and review health assessments. This identified further areas for improvement and an action plan was put in place.

7. Activity from 1st October 2013 – 31st March 2014

8. Notifications and Initial Health Assessments (IHA)

From 1st October electronic data collection systems were established to capture activity and identify target areas for improvement. Since then there has been progress in all areas. Notifications are now in the main received within timescales. On receipt of this information from CSC, 100% of all children new into care are immediately allocated an appointment for IHA. The average time for an appointment between April 2013 and July 2013 was **58** days. This

year in the same period the average wait is **16** days and ensures that CIC are seen within the statutory 28 days of coming into care.

9. Review health assessments (RHA)

There was some delay in RHA's being undertaken and the delay was due to a variety of factors including out of borough placements or health staff not informed of change of placement , In quarter 4, **72%** (55) children had an RHA within timescales. Due to similar reasons as stated above. This has continued to improve and will remain a priority for health practitioners in Halton.

10.Health Profile of Children in Care in Halton

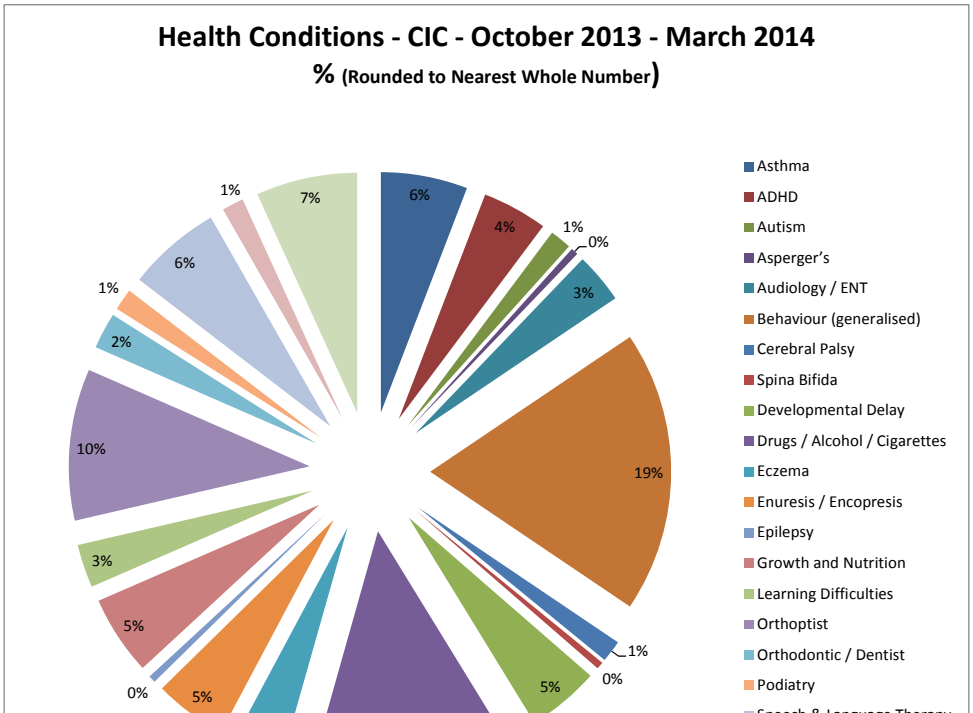
An audit of the information from health assessments October 2013 – March 2014 has identified a variety of health conditions/health needs of CIC. Some children and young people are living with more than one condition. Children's health needs and progress are currently recorded in their health plan. However there is at present, no data available electronically in relation to measuring and tracking their health outcomes.

It is proposed that in future, individual children and young people's health outcomes will be recorded by their health professional and the information forwarded to the Children in Care Nursing team. The team will undertake management overview of each child's health plan where there are unmet health needs to ensure this data is available in future.

The chart below outlines the identified health conditions present at either the initial or review health assessment. The number of children with a disability is unknown in the main due to reporting and absence of diagnosis at the initial/review assessment. Disability may become apparent following health assessments.

Health needs will be addressed by the health professional, GP or specialist services. Referrals will be made to the most appropriate service/agency.

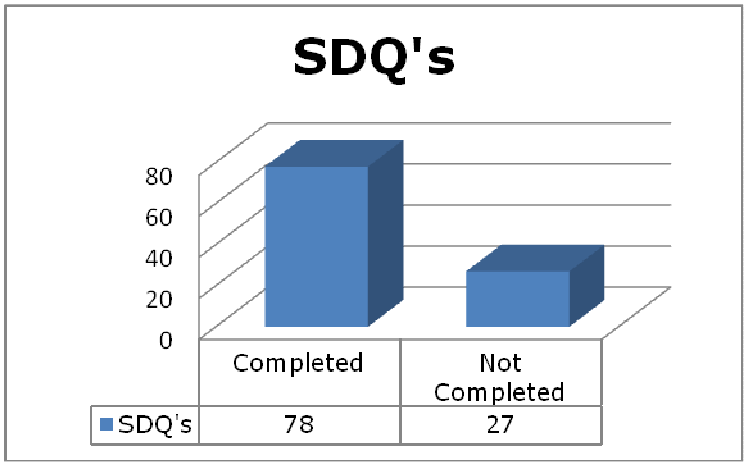
	Health Condition	Number Diagnosed	%
1	Asthma	12	5.82%
2	ADHD (Attention Deficit Hyperactivity Disorder)	9	4.36%
3	Autism	3	1.45%
4	Asperger's	1	0.48%
5	Audiology / ENT	7	3.39%
6	Behaviour (generalised)	39	18.93%
	The behavioural issues range from temper tantrums, head banging, rocking and soiling in the younger children to emotional outbursts, aggression and self-harming tendencies in the older children and young people. It is also included absconding or missed from care episodes with increased risk for the Child or Young Persons safety.		
7	Cerebral Palsy	3	1.45%
8	Spina Bifida	1	0.48%
9	Developmental Delay	10	4.85%
10	Drugs / Alcohol / Cigarettes	27	13.10%
	Admitted to smoking cannabis	*10*	
	Admitted to smoking cigarettes	*16*	
	Admitted to inhaling aerosol gas	*1*	
	Please note the majority of young people who smoked cigarettes also smoked cannabis		
11	Eczema	7	3.39%
12	Enuresis / Encopresis (bedwetting & soiling)	10	4.85%
13	Epilepsy	1	0.48%
14	Growth and Nutrition	11	5.33%
15	Learning Difficulties	6	2.91%
16	Orthoptist (Vision)	21	10.19%
17	Orthodontic / Dentist	5	2.42%
18	Podiatry	3	1.45%
19	Speech & Language Therapy	13	6.31%
20	Sexual Health	3	1.45%
21	Specific Health Conditions	14	6.79%
	Chromosomal Disorder	*3*	
	Undescended Testicles	*2*	
	Monitoring due to premature	*2*	
	Psychological Assessments	*2*	
	Cardiology Review	*1*	
	Nut Allergy	*2*	
	Tongue-Tied	*1*	
	Talipes / orthopaedic	*1*	



11.Behaviour and Emotional Wellbeing

Some children and young people in care experience emotional distress and subsequent behavioural problems as evident in the 20% identified through health assessments. However it should be noted that according to National Institute of Clinical Excellence (NICE), 66% of children in care have unmet mental health needs. As a consequence early identification of problems through vigilance will help improve outcomes for children. Mental health needs are assessed as part of the health assessment, self-report from children and young people, from carers and social workers. A Strengths and Difficulties questionnaire (SDQ) is a screening tool and is completed for all children over 3 years to assess behaviour problems, emotional issues, peer problems and hyperactivity. Young people over 11 years may be asked to complete an SDQ and in some cases teachers are requested to complete a questionnaire for a particular child.

For the **105** children in the cohort for the returns 92% of SDQ's were returned. **20** were exempt as they were under 4 and over 17. **2** were exempt for medical reasons and **5** were not returned. The average score for these was **12.7** which was a decrease on previous years. (See graph below).



SDQ's – 92% Returned

Out of the 105 children for SDQ's the rationale is as follows:

20 Exempt – Under 4 and Over 17

2 Exempt – Medical Reasons

5 Not returned

Average Score 12.7 decrease

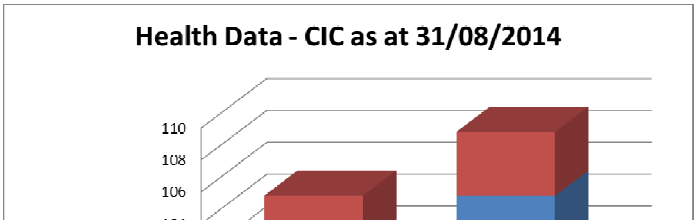
If a child has a score of over 13 the Children in Care Nurse will have a discussion with the child's social worker and if necessary a referral will be made to Barnardo's Go4Ward Emotional Health and Wellbeing service who provide a tier 2 emotional health service for Children in Care in Halton (not CICOLA's). For children under 3 years emotional health and behaviour questionnaires are completed by carers. Children assessed with mental health needs who require tier 3 or specialist CAMHS provision (tier 4) will be provided with those services by the Five Boroughs Partnership. According to data provided by Barnardo's (2014) from April 2013 until March 2014 (Barnardo's 2014) **47** children (24 males and 23 females) were referred to the Go4Ward Service by social workers, carers and school health nurses. **9** of the **47** children were reported as having a disability as a result of behaviour. As expected, behaviour issues were predominant in **36** cases. Also issues with family (**18**) and anger (**16**) were recorded.

12.Immunisation

Some children when they enter care are not always up to date with their immunisation. Carers are asked to ensure that children attend the GP or practice nurse to complete the course. Also the CIC Nurse and the School Health Nurse will also address outstanding immunisations and offer to visit the children at home to immunise. The immunisation rate for year ending 2014 was **97%** of all children were immunised. Out of **105** children in this cohort **3** refused. (See graph below)

13.Dental Services

All Children in Care are provided with dental care by registered dental practitioners or the Priority Dental Scheme at Widnes Healthcare Resource Centre and Hallwood Health Centre. Out of **105** children receiving dental treatment **96%** were in the care of a dentist. Information for **4** children was not available at the time of this report.



Immunisations – 97%

Out of the 105 children receiving immunisations 3 refused

14.Sexual Health Services

Health professionals will offer appropriate sexual advice and guidance and signpost young people to the various sexual health services available in Halton.

15.Substance Misuse Services

Drug and alcohol brief intervention and advice is provided by health professionals undertaking health assessments. Children and young people can also self-refer to Young Addaction who are responsible for service delivery in Halton.

16.Training

A comprehensive training package for health care has been developed by the CIC Nurse for foster carers. "Passport to Health" is a course delivered by the CIC Nurse which incorporates healthy eating and physical activity. Further courses such as common childhood ailments and teenage adolescent behaviour are also offered throughout the year.

For private providers caring for the CICOLA's the CIC Nurse undertakes Medicine Management advice and training. Also bespoke training on request and include healthy lifestyles for young people.

The CIC Nurse also undertakes training with professionals including social workers and health professionals in relation to processes and procedures. The CIC Nurse also participates in the multi-agency training delivered by the Conference and Reviewing Managers.

17.Asthma/Allergy training

The School Nurse allergy lead in Bridgewater also provides allergy and asthma training to foster carers. This includes allergy training in relation to managing conditions when children are undertaking out of door activities such as outings with scouts. The Nurse will also formulate and monitor allergy care plans for children with allergies and will liaise with the child/young person's social worker.

18.Care Leavers

There are **66** Care leavers in Halton at end of March 2014. All Care Leavers are offered an appointment with the CIC Nurse to discuss how best to capture their health history. The young person is provided with a health summary to ensure that they have all relevant health details when they are no longer in care.

19.Children and Young people placed in Halton by other local authorities.

As previously stated the number of CICOLA's in Halton has consistently been above 150 – 160. The CIC Nurse works in conjunction with Halton Borough Council Children's Commissioners and Education Services to ensure that all children/young people placed in Halton are accounted for by both health and social care. There are some loopholes despite legislation and on occasion children may be living in Halton of whom we are not aware as we do not receive notification from the placing authority.

20.Multi agency meetings to promote the health and well-being of CIC

The CIC Nursing team and Named Nurse are actively involved in multi-agency forums such as Healthy Care, the Emotional health and wellbeing meeting and the CIC Partnership board.

21.Plans for the future

- Continue to monitor and audit the health assessment process.
- Refine data collection systems to capture information about health outcomes including CICOLA's.
- Update our training programme to ensure all professionals are aware of the CIC processes and procedures.
- Undertaking a CQUIN action plan (Commissioning for quality and Innovation) the focus of which is on the quality of service delivery and good outcomes for CIC. This involves use of a personal action plan for each child when health needs are identified and progress will be tracked by the use of a RAG system of rating progress and outcomes.

22.Conclusion

There has been considerable improvement in children receiving a timely service to ensure that their health needs are identified and addressed. Communication has improved to the extent that the majority of notifications for children new into care are received within time-frames. 100% of children placed in Halton Borough are allocated an appointment for a health assessment as soon as notification is received by the CIC nursing team.

Within Bridgewater various forums monitor the action plan for CIC which include both the Safeguarding Operational Group and Safeguarding Assurance Group. The latter group reports to Bridgewater Board.

There is still room for improvement and we will continue to ensure that CIC are offered a service of the highest quality to meet each child/young person's needs. The child's voice and wishes and feelings will continue to be captured as part of the assessment. This will help to influence service delivery in the future.